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THE POLYCLINIC

BEING THE JOURNAL OF THE

MEDICAL GRADUATES' COLLEGE

*PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION OF
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BY

JONATHAN HUTCHINSON

VOL. II.

JANUARY TO JUNE, 1900

London:

JOHN BALE, SONS & DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, W.

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- Jones, Geo. Manders, L.R.C.P., Linqunda, 47, Wood Vale, Forest Hill.
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- Keane, Bernard, L.R.C.P., Guardian's Office, Bancroft Road, Mile End Road.
- Keele, David, M.R.C.S., 160, St. Paul's Road, Highbury.
- Kellgren, Arvid, M.D., 94, Cromwell Road, S.W.
- Kelson, W. H., M.D., 96, Queen Street, Cheapside, E.C.
- Kennedy, J. A., M.D., The Lindens, Bearsden, Dumbartonshire.
- Keogh, A., M.D., care of Messrs. Holt and Co., 17, Whitehall Place.
- Kingscote, E., M.B., 31, Lower Seymour Street, W.
- Kisch, A., M.R.C.S., 61, Portsdown Road, W.
- Kynsey, Sir W., F.R.C.P., Oriental Club, Hanover Square.
- Laird, John, L.R.C.P., 2, Stafford Place, Buckingham Gate.
- Lake, R., F.R.C.S., 19, Harley Street, W.
- Lamb, W. H., M.B., 23, Palace Court, W.
- Lambert, J. S., M.R.C.S., H.M.S. Narcissus, Portsmouth.
- Lane, H. Angell, M.R.C.S., 252, Mile End Road, E.
- Latham, A., M.B., 27, Grosvenor Street, W.
- Lavers, Norman, M.R.C.S., Camberwell House, Peckham Road, S.E.
- Lawford, J. B., M.D., 99, Harley Street, W.
- Lawson, H. A. W., L.R.C.P., 46, Leytonstone Road, Stratford.
- Lee, W. S., L.R.C.P., 323, King's Road, Chelsea.
- Legg, T. Percy, M.B., Royal Free Hospital, W.C.
- Lendon, E. H., M.B., 162, Holland Park Avenue.
- Levy, Maurice, M.D., 49, Priory Road, West Hampstead, N.W.
- Levy, Oscar, M.D., 2, Vernon Place, Bloomsbury Square.

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 Ling, M. E., M.R.C.S., 5, West Halkin Street, Belgrave Square.
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 Lloyd, W. J., L.R.C.P., 4, Alfred Place, South Kensington.
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- McBride, Anthony, M.B., 1, Great Percy Street, W.C.
 McCall, Anthony, M.B., care of Mr. Hattersley, Albion House, Doncaster.
 McCarthy, E. F., L.R.C.P.I., 124, Gower Street, W.C.
 McCaw, J. Dysart, M.D., East Finchley, N.
 McDonnell, M. A., M.D., 145, Harley Street, W.
 Macevoy, H. J., M.D., 41, Buckley Road, Brondesbury, N.W.
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 Macgregor, P., M.D., Cambridge Park, Wanstead.
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 Mackenzie, A. G., F.R.C.S., Much Wenlock, Shropshire.
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 Maclean, J. N., M.B., Penrose Lodge, Upper Tooting, S.W.
 MacLellan, W., M.R.C.S., Keble Villa, Chiswick.
 MacLelland, Robert, M.D., 28, Avenue Mansions, South Hampstead, N.W.
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 MacLeod, K., M.D., Colonel, The Towers, Woolston, Hants.
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 Macnamara, J. M., M.D., 73, Milson Road, West Kensington.
 MacRae, W. E., M.B., 27A, Lowndes Street, Belgrave Square, S.W.
 Maguire, M., M.B., Glengariff, Kew Road, Richmond.
 Mailer, W., M.B., Holmwood, Palace Gates Road, Wood Green.
 Main, Robert, M.D., 24, Alexandra Villas, Finsbury Park.
 Maitland, Pelham C., M.R.C.S., 4, Thurloe Place, South Kensington.
 Malcolm, J. D., M.R.C.S., 13, Portman Street, W.
 Malpas, Douglas D., M.D., Chalet Jeremie, Biarritz, France.
 Manson, Patrick, M.D., 21, Queen Anne Street, W.
 Marriott, Charles W., M.R.C.P., Aubrey House, Bath Road, Reading.
 Martin, H. J. W., M.R.C.S., West Grove, Mill Hill, N.W.
 Marsh, Ernest L., M.B., 35, Marine Lines, Fort, Bombay.
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May, E. Hooper, F.R.C.S., High Cross, Tottenham.
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 Miller, James Duff, M.B., 152, Holland Park Avenue, W.
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 Moore, W. W., M.B., 1, Westbourne Road, Barnsbury.
 Morier, C. G., L.R.C.P., Adelaide, Australia.
 Morison, Alex., M.D., 14, Upper Berkeley Street, W.
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 Mostertz, Julius, L.S.A., 78, Lordship Lane, Wood Green, N.
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 Mowat, D., M.D., 123, Stamford Hill, N.
 Moxey, Vincent, M.R.C.S., 85, Carleton Road, Tufnell Park, N.
 Muir, T. Rennie, M.B., Abertillery, Monmouthshire.
 Munro, W. J., M.B., 4, Roman Road, Bedford Park Estate, Turnham Green.
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 Newman, W., M.D. Lond., 17, Barn Hill, Stamford.
 Nisbet, W. B., M.B., Townsland, Queensland.
 Noott, W. M., M.R.C.S., 8, Kensington Park Road, W.
 Norman, R. L., M.R.C.S., 26, Walton Street, S.W.
 Norris, F. B., M.D., 7, Oak Hill, Surbiton.
 Nott, A. H., Captain, M.B., care of Messrs. Grindlay & Co., 54, Parliament Street.
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 Nourse, W. J. C., F.R.C.S., Abchurch House, Sherborne Lane, King William Street.
 Nuttall, R., M.R.C.S., Devon Villa, **11**, Finsbury Park Road.

Oberfoell, A., M.D. Freiburg, 524, Oxford Street.
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 Phillips, H. Whitby, M.D., 22, Addiscombe Road, East Croydon.
 Pickett, J., M.D., 26, Colville Square, W.
 Pidcock, G. Douglas, M.D., 74, Fitzjohn's Avenue, Hampstead.
 Pike, Thelwell, M.D., 37, Walbrook, E.C.
 Plaister, W. H., M.R.C.S., Pembury House, Tottenham.
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 Pollard, J., M.R.C.S., 51, Queen Anne Street, W.
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 Powell, W. Wyndham, F.R.C.S., 16, Old Burlington Street, W.
 Prescott, Thos., M.R.C.S., 35, Great Queen Street, Lincoln's Inn Fields.
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 Pridmore, Campbell W., L.S.A., 116, Jamaica Road, Bermondsey.
 Pritchard, Owen, M.D., 41, Gloucester Square, W.
 Pruen, S. T., M.D., Sherborne Lodge, Cheltenham.
 Purdie, R., M.B., 81, Queen's Crescent, N.W.
 Putsey, W. H., M.D., Junior United Service Club.

 Quay, F. A. W., M.R.C.S., 22, Wiltshire Road, Brixton, S.W.

 Ralph, R. M., M.D., St. Mary's Children's Hospital, Plaistow.
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 Ray, E. Reynolds, M.R.C.S., 15A, Upper Brook Street, W.
 Reed, Geo., M.D., 59, Canonbury Park, N.
 Renner, C., M.D., 186, Marylebone Road, N.W.
 Reynolds, Austin E., M.R.C.S., 81, Hornsey Rise, N.
 Reynolds, G. Hay, M.B., 30, Frognal, Hampstead, N.W.
 Richardson, G., M.D., Hillside, Putney Hill.
 Richardson, Timothy, M.R.C.S., 530, Commercial Road, E.
 Richardson, T., L.R.C.P., 114, Highbury New Park.
 Rigden, W., M.D., 16, Thurloe Place, S.W.
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- Robinson, Tom, M.D., 9, Prince's Street, Cavendish Square.
 Robinson, W. J. B., M.D., 16A, Old Cavendish Street, W.
 Robson, Mayo A. W., F.R.C.S., 7, Park Square, Leeds.
 Roe, W. F., L.R.C.P., 78, Charlotte Street, W.
 Rolston, C. M., M.D., care of Dr. Cameron, Lily Bank, Inverleithen.
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 Ross, F. W., M.D., 15, Gower Street, W.C.
 Ross, T. Mackay, M.B., 21, Cremorne Road, Chelsea.
 Roth, Bernard, F.R.C.S., 38, Harley Street, W.
 Rotheroe, W. Burslem, L.R.C.S., 47, Gloucester Place, W.
 Routh, Amand, M.D., 14A, Manchester Square, W.
 Rushbrooke, T., M.R.C.S., Melrose, 93, Stamford Hill, N.
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 Sangster, C., M.R.C.S., 148, Lambeth Road, S.E.
 Satchell, W. A., M.R.C.S., 33, Mount Park Crescent, Ealing.
 Savage, G. H., M.D., 3, Henrietta Street, W.
 Savill, Thos., M.D., 60, Upper Berkeley Street, W.
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 Seccombe, P. J. A., M.B., 45, Madeley Road, Ealing, W.
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 Sharpe, W. Cecil, M.B., The Red House, Darley Dale, Matlock.
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 Shaw, John, M.R.C.P., 32, New Cavendish Street, W.
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 Shuttleworth, G. E., M.D., Ancaster House, Richmond Hill.
 Sibley, W. Knowsley, M.D., 8, Duke Street Mansions, Grosvenor Square, W.
 Simpson, C. S., M.R.C.S., 125, Southgate Road.
 Simpson, C. M., M.R.C.S., 7, Highbury Crescent.
 Simpson, F. Hampson, M.D., 32, Weymouth Street, W.
 Sinclair, A. M. Ross, M.B., 231, New King's Road, Parson's Green.
 Slimon, G. C., M.D., Red House, Mare Street, Hackney, N.E.
 Smalley, Herbert, M.D., Prison Commission, Home Office, Whitehall.
 Smith, Burnett J., M.B., Aldersyde, Lindfield Gardens, Hampstead.
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 Smith, Heywood, M.D., 18, Harley Street, W.
 Smith, Hugh, M.D., Englefield House, Highgate, N.
 Smith, J. C., M.R.C.S., Rhine Villa, Shoot-up Hill, Brondesbury.
 Smith, Noble, F.R.C.S., 24, Queen Anne Street, W.
 Smith, Percy R., M.D., 36, Queen Anne Street, W.
 Smith-Pye, R., F.R.C.S., 350, Glossop Road, Sheffield.
 Smith, S. Parsons, L.R.C.P., Park Hyrst, Addiscombe Road, Croydon.
 Smith, Solomon, M.D., Four Oaks, Walton-on-Thames.

- Smith, W. R., M.D., King's College, Strand.
 Smythe, A. C. Butler, F.R.C.S., 76, Brook Street, W.
 Snape, Ernest, M.D., 41, Welbeck Street, W.
 Snell, E. Arthur, M.B., 70, City Road, E.C.
 Sommerville, D., M.D., 11, Brunswick Square, W.C.
 Spicer, Scanes, M.D., 28, Welbeck Street, W.
 Sprigge, S. Squire, M.B., 2, Essex Villas, Kensington, W.
 Spurrier, A. H., L.R.C.P., Zanzibar.
 Squire, J. E., M.D., 122, Harley Street, W.
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 Stapleton, Joseph, M.D., Lambton, New South Wales, Australia.
 Startin, James, M.R.C.S., 15, Harley Street, W.
 Stephenson, Sydney, M.B., 33, Welbeck Street, W.
 Stewart, Hastings, M.R.C.S., 8, Albany Court Yard, Piccadilly.
 Stewart, H. M., M.D., Walton House, Lordship Lane, S.E.
 Stocker, Chas. J., M.R.C.S., Richmond Gardens, Forest Gate.
 Stoddart, W. H., M.D., Bethlem Royal Hospital.
 Stokes, H. Fraser, M.D., 2, Highbury Crescent, N.
 Stoney, Ralph, L.R.C.S., 11, Gloucester Terrace, S.W.
 Stonham, C., F.R.C.S., 4, Harley Street, W.
 Stowers, J. H., M.D., 128, Harley Street, W.
 Suffield, Thos., L.R.C.P., 10, Moor Street, Soho.
 Sumpter, W. J. Erneley, L.R.C.P., Sheringham, Norfolk.
 Sutherland, Geo., M.D., 9, Old Cavendish Street, W.
 Sworn, H. G., L.R.C.P., 5, Highbury Crescent.

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 Taylor, Reginald, M.R.C.S., 79, Gray's Inn Road, W.C.
 Taylor, Seymour, M.D., 16, Seymour Street, W.
 Taylor, W. Bramley, M.R.C.S., 145, Denmark Hill, S.E.
 Taylor, W., M.D., Brookfield, Upper Tooting.
 Thomarson, J., M.B., 8, Wynand Villas, Palmerston Road, Bowes Park.
 Thompson, C. H., M.D., 17, New Cavendish Street, W.
 Thompson, James A. B., M.D., White Hall, Abridge, Essex.
 Thompson, Symes, M.D., 33, Cavendish Square, W.
 Thomson, G. Crawford, M.D., 111, Sinclair Road, West Kensington Park.
 Thomson, St. Clair, M.D., 28, Queen Anne Street, W.
 Thorne, Atwood, M.B., 10, Nottingham Place, W.
 Thornhill, W. H., Lieut.-Colonel, M.D., 54, Chepstow Villas, Bayswater.
 Thurston, D., L.S.A., 160, Euston Road, N.W.
 Tibbles, John J., M.R.C.S., St. Monan's, Melton Mowbray.
 Tilley, Herbert, M.D., 101, Harley Street, W.
 Todd, Henry Ross, L.R.C.S.I., West Hall, Warlingham, Surrey.
 Tuchmann, M., M.D., 47, Finsbury Square.
 Tuohy, J. T., Major, I.M.S., 42, Jermyn Street, W.

 Usher, J. E., M.D., 20, Queen Anne Street, W.

 Vinrace, Felix, M.D., 27, Temple Row, Birmingham.

Wadia, D. R., M.D., Parel, Bombay.
 Walker, Geo., M.D., 35, Wood Vale, Lordship Lane, S.E.
 Wallace, A., M.D., 39, Harley Street, W.
 Walters, F. Rufenacht, M.D., 60, Welbeck Street, W.
 Walters, J., M.B., Reigate, Surrey.
 Ward, A. Ogier, M.D., 73, Cheapside, E.C.
 Warner, F. Ashton, F.R.C.S., 10, Brechin Place, South Kensington.
 Whait, J. R., M.B., Charltons, Fairhazel Gardens, South Hampstead.
 Whitcombe, P. P., M.B., 164, Earl's Court Road, S.W.
 Whitehall-Cooke, C., M.D., Higham Ferrers, Walm Lane, Cricklewood.
 Whitton, J., M.D., Springfield, Stradbally, Queen's County, Ireland.
 Wickham, O. A., M.R.C.S., 1, Westbourne Road, Barnsbury.
 Wightwick, J. P., M.D., 9, Upper Brook Street, W.
 Willey, J. Ingor, M.B., 23, Henrietta Street, W.
 Williams, G. J., M.B., 67, Prince's Square, Bayswater.
 Williams, John, M.B., 30, Connaught Street, W.
 Williams-Monier, M., M.R.C.S., 54, Onslow Gardens, S.W.
 Winstanley, R. H., L.R.C.P., Haslemere, Surrey.
 Withinshaw, C. W., L.R.C.P., 225, South Lambeth Road, S.W.
 Woakes, Ed., M.D., 78, Harley Street, W.
 Wood, Ed., L.R.C.P., Glebe Lodge, Windmill Hill, Enfield.
 Wood, T. Neville, M.R.C.P., 42, Elvaston Place, S.W.
 Woodforde, A. P., M.R.C.S., 60, Goldhawk Road, Shepherd's Bush.
 Woods, D., M.D., 3, Regent's Park Road, Gloucester Gate.
 Worrall, E. S., L.R.C.P., 78, Cecile Park, Crouch End.
 Wright, Dudley, F.R.C.S., 55, Queen Anne Street, W.
 Wylie, A., M.D., 323, Clapham Road, S.W.

Yearsley, Macleod, F.R.C.S., 33, Weymouth Street, W.
 Yolland, J. H., M.R.C.S., 53, Bromley Common, Kent.

Total number enrolled ....	....	....	....	....	....	535
Applications additional	....	....	....	....	....	26

APPLICATIONS TO BE ENROLLED AS MEMBERS NOT YET PASSED
UPON.

- W. G. Bigger, M.B., Aberfoyle, Streatham Common, S.W.
 F. M. Haig, M.D., Hazel Bank, South Nutfield, Surrey.
 J. Albert Bell, M.R.C.S., Deravona, Rochester
 George Roehrung, M.D. Berne.
 E. L. de Chazal, M.D. Lond., M.R.C.S., 66, Albert Street, Regent's Park.
 James McMunn, L.R.C.P.I., 44, Finsbury Pavement, E.C.
 Dr. John Forbes, 7, Robert Street, N.W.
 H. B. Milsome, M.B., B.C., Chertsey.
 Ernest E. Maddox, M.D., Warleigh, Bournemouth.
 J. Howard, M.B., R.U.I., 34, Wickham Street, Limerick.
 David J. Lawson, M.D. Edin., Fortuna's Well, Portland, Dorset.
 Stanley Smith, M.D., 68, Wimpole Street, W.
 A. J. Drew, F.R.C.S., Water Hall, St. Aldate's, Oxford.
 J. J. Taylor, M.D., Gomersall Hall, near Leeds.
 J. Hopkins Walters, M.R.C.S., 15, Friar Street, Reading.
 R. C. Stewart, M.B., B.Ch., 30, Cloudesley Street, Barnsbury.
 G. H. Rutter, M.B., Wootton Bassett, Wilts.
 R. O. Moon, M.R.C.S., L.R.C.P., 16, St. Peter Street, Winchester.
 S. L. Martin, L.S.A., 55, Oxford Terrace, Hyde Park.
 Howard Gladstone, M.D., West House, Stanstead Road, Forest Hill, S.E.
 W. Harle, M.R.C.S., 4, Darnley Road, Hackney.
 H. W. Beedham, M.B., B.C., 124, Mill Lane, West Hampstead.
 F. C. Tothill, M.B., C.M. Edin., 93, High Street, Staines.
 E. M. Cuffe, M.D., Thrale Hall, Streatham, S.W.
 Joseph Frank Payne, M.D., 78, Wimpole Street, W.
 And. Murdoch, M.B., C.M. Glasg., 34, Albert Road, Bexhill.
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THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. II., No. 1.—JANUARY, 1900.

EDITOR'S ADDRESS.

THE objects aimed at by the Council of the Polyclinic College in deciding to have a Journal of its own are twofold. It is desired in the first place to afford information, month by month, as to the Teaching Classes, Courses of Lectures, &c., which have been arranged; and in the second to record the results of our Consultation work. It is designed that the Journal shall contain 64 pages, and shall appear during the first week of every month. Four-fifths of its space will probably be taken up by subjects coming under the second of the two objects, and thus the Journal will be in the main a record of facts in Clinical Medicine and Surgery. No original articles will be asked for; our Review Notices of the Books sent to us will be but brief; and our references to professional events outside our own walls will be restricted to a few pages of Notes, and to the column devoted to Correspondents.

Thus our Journal will not compete with any other, but will be almost solely a record of our own proceedings. For our members it will supply promptly, in permanent form, authentic notes of most of the more important cases which have been brought under their notice in the consultation theatres. In some instances it may even be possible to print the notes before the consultation takes place, and thus prepare

the way for profitable observation ; and in many in which the same patient attends repeatedly, the case-record will be at hand in the Journal for reference. No pains will be spared to make our pages an instructive commentary upon our consultation work, and in so doing we hope to afford to those of our readers who may not be able to attend regularly, or perhaps not at all, as good a substitute as printed material can be for actual observation. It has long been an opinion of my own, and one which I have often expressed, that our Medical Schools do not sufficiently utilise the printing press as an aid to ward-teaching, and that, instead of annual volumes of Hospital Reports, consisting of elaborate essays, it would be better to issue monthly, or, best of all, weekly, a chronicle of what was going on in the wards, to which students should have immediate access. Our medical journals have done something, and very meritoriously, to supply this need, but it is impossible that outsiders should achieve adequately a task which ought naturally to devolve upon the hospital staff. Holding these views, it has been with much pleasure that I have acceded to the wish of my colleagues that I should attempt something of the kind referred to for our Polyclinic, and should become, for a time at least, the Editor of our Journal. I have accepted the post with much misgiving as to personal fitness, but intend to do my best.

It may, perhaps, be alleged that, after all, the Polyclinic is not a Hospital, and it may be desirable that I should offer a few words of explanation on this head. Our patients do not attend for continuous treatment, and we have no beds. They come for advice only, and are usually brought or sent by medical men. Some of them—and some of the best for clinical teaching—are supplied to us as cases of unusual interest from the workhouse infirmaries, dispensaries, &c., which abound in the Metropolis. Thus, whilst our organisation precludes, it is to be admitted, certain classes of cases, such as severe accidents, operations, and acute diseases, it has the advantage of not burdening our staff, either as regards time or energy, with frequent repetitions of the more ordinary and less instructive forms of disease. All that we get is, for clinical purposes, good, and much of it is excellent. During the

six months that our clinical classes have been open, it may, without boasting, be claimed that we have had before us some of the most typical examples of the rarest and most instructive forms of disease. As our young Institution becomes better known, we hope to attract more and more cases of this class, and, by means of our Journal, to rescue much valuable material which might otherwise be lost to medical literature.

As regards what we cannot attempt, it may be said that the promoters of the Polyclinic never had the slightest notion of coming into any sort of competition with the great Hospitals. Our hope was that, whilst achieving our own special vocation, we might also be allowed to become ancillary to theirs. This hope we still entertain, and it will give us pleasure if our Bureau or our Journal can be made the medium of giving information to strangers in London as to the opportunities open to them in other larger and far more important institutions. Our vocation will be, in the main, to afford instruction in Diagnosis, Methods of Research, and Pathology; and we must leave most of what concerns Operative Surgery, and much of that which deals with Surgical treatment, in other hands. Notwithstanding these limitations, however, we still feel that we have a great and a very useful work before us.

JONATHAN HUTCHINSON.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON CASES OF ANGINA.

BY WM. MILLER ORD, M.D., F.R.C.P.

October 10th, 1899.

GENTLEMEN,—The symptoms related clearly put this case under the head of Angina. From a short statement elicited it appears that he has a distressing pain in the epigastrium which he cannot very well describe. It is not an acute pain, but rather a pain which makes him feel that he is unable to draw his breath properly. He states that it occurs when he moves about after being quiet, and that he is compelled to stop walking, to hold on to something, and to wait. Apparently, he waits in faith that he will get better in a minute or two, and then he can walk on further. He states, moreover, that he has no attacks of the kind at night. I have enquired whether these attacks come on more in the earlier part of the day or in the latter, and he answers that they occur in the latter part.

Given a man who comes to us with a story of this kind, of course one would make a careful physical examination, but we must have certain ideas guiding us in our examination. What will give rise to this class of anginoid pains? It has long been taught that the first and original cause is weakness of the heart itself—impairment of the nutrition of the heart-wall. The teaching of my student days was that angina pectoris was the result of ossification or calcification of the coronary arteries and consequent defect of nutrition in the walls of the heart. Well, that was true as far as it went, but it was very inadequate, and the more one studies cases presenting symptoms such as we have just had put before us the more one is obliged to recognise a very great variety of causes and influences. First, certainly, we must recognise the degeneration of the heart muscle—often a thing of real importance. Again, we have to admit the existence in many cases of

organic disease of the valves of the heart, not only affecting the nutrition of the heart, but disturbing the balance between the heart and the arteries, and further we must consider the peripheral arteries and recognise the great importance of arterial tension in the production of anginal attacks. And there are a great many curious subsidiary points: points of neurosis and points like one which I have been induced to study a good deal of late, viz., the co-existence of glycosuria with attacks of angina. So that whenever a man comes with angina it is not for us a mere question of examining the heart to see whether there is a weakened first sound and an impaired impulse, but the broader problem whether there is valvular disease, hypertrophy, wasting or dilatation of the heart, whether there be arterial disease or other conditions at work in the body which may bring about arterial tension too readily. Will you forgive me if I go on to analyse some of these cases? They are cases that are of great importance to us in our ordinary practice, not only in the way of treatment but also in the way of prognosis.

First let us think of those cases in which it is the question of a feeble heart. All of us who have dealt much with sick people will know that there are persons who have a feeble, ill-nourished heart, almost inevitably with over-irritability of the nervous system, who come with signs of angina yet present no local mischief that you can well define. We may find that there is an enfeebled heart-beat, but very often not even that. When we meet a nervous person complaining of attacks, not so much of pain as of difficulty in breathing, and a feeling as if he will die, we have to be very careful before we tell him that he will not die. My experience of that kind of man is that he is very apt to die suddenly in spite of the best treatment and encouragement. There has been good reason for his fears but we have not fully grasped it. I always look with very great anxiety on a case which gives those symptoms without my being able to lay my finger on any local or constitutional cause to account for it.

Another group includes patients with definite signs of valvular disease of the heart and with various related impairments of the heart-wall. One can here easily understand why there should be anginoid attacks under exertion or excitement of any kind. But we must certainly recognise that there are a good many people who appear to have perfectly healthy hearts and yet have signs of angina well

developed. These are sometimes patients with evident alteration in the peripheral arteries; alterations in the way of atheroma or, more particularly, calcareous degeneration, and there are, again, patients who have renal disease or various other kinds of disease in the body, which have led to alterations of another kind in the blood vessels, constantly determining the occurrence of arterial tension to a more or less excessive degree.

The patient before us has certainly changes about his heart; it is enlarged, its beat is not strong, but has rather a tumultuous character. There is just a suspicion of mitral regurgitation, and there is certainly a distinct basic murmur, indicating aortic obstruction. His arteries are thickened and somewhat firm; his age is 70. It is quite evident from a general view of him that he is degenerating. He has had double cataract, for which he has undergone an operation, considerable dystrophic changes have taken place in his joints, and he is pallid. I have examined his urine carefully, but I can find no evidence of either Bright's disease or of diabetes. There is neither albumen nor sugar in the urine, although he says he has had "a little trouble" with it. I should say that here we have a man who is, in the first place, altogether anæmic and degenerated, next a man presenting arterial degeneration and narrowing of the aortic valve, with dilatation of the heart, and enfeeblement of its power, with the result that under any excess of excitement or exertion the ventricles, particularly the left, are incapable of performing their function properly, and become over-distended. Then the characteristic pain follows.

A case like this almost tempts one to go from a consultation into something like a clinical lecture. In my experience hardly a week passes without my having to deal with conditions resembling this, in one way or another, and just so often it is necessary to balance very carefully the respective influences that I have tried to put before you as briefly as possible.

Here we have a man with a weak heart-wall no doubt and a dilated heart, and in addition to that obstruction at the aortic valve, contracted and very much thickened arteries, such as are incapable of much distension. Then he is anæmic and feeble, clearly a degenerating subject.

When we are dealing with people suffering from one or other form of this anginoid the prognosis is always a thing to be remembered, and it

is not one of the cases in which I should ever feel myself justified in giving a too light-hearted opinion. Sharp lessons have taught me that it is a great mistake to make light of such attacks and to say that there is nothing the matter, even though the attacks seem to be purely nervous. On the other hand, of course, one has to be very careful to avoid the arousing of disproportionate anxiety. The word "anginoid" is a terrible word, the public knows what it means, and we have to qualify it by the use of such words as "breast-pang" and others that may convey to the patient the sense of the disorder of the circulation without, so to speak, signing his death warrant.

We now come to the point of management and treatment. I think we may all admit that when attacks of the kind in question come on trinitrin (nitro-glycerine) or nitrite of amyl are the most effective remedies we can have recourse to. As a rule I think it is wise to provide the patient with tabloids containing the one-hundredth of a grain of trinitrin, preferably I think to anything else, or nitrite of amyl, in capsules, if that be the drug indicated. I think it is always wise to let a man have the drug in a form which he can readily carry about with him, and have, so to speak, an insurance as he goes along. The confidence that a man gains after using them once or twice is of enormous importance. I have known a man who if he started out to his work without them would be attacked speedily, but when he knew he had got his palladium in his pocket would escape attack.

The next thing that I think we have to do in all cases is to investigate carefully the conditions under which attacks most commonly occur. In a very large proportion of cases they come on when people begin to move about actively after a meal. One of the commonest things is for the patient to be attacked after breakfast when he is going off to his office in the city, and either runs or hurries to catch a train. Of course, if it occurs in that way, you at once are bound to institute arrangements by which he shall not hurry after breakfast: that he shall eat it quietly, and sit still for a little time after it, and then go off quietly to business. If able to do it, he might go better in a cab than in an omnibus, and better in an omnibus than on foot. He should avoid the troubles incidental to our underground railways, where it is necessary to ascend long staircases. The most severe attacks are brought on when the patient walks out from a warm room into the open and encounters a cold wind.

The next point is of very great importance, viz., the action of the bowels. Directly a man has any amount of constipation, arterial tension is increased, and naturally the chances of anginoid attacks are increased in the same proportion. For a patient suffering from this condition, the first duty of a physician is to ensure daily relief of the bowels. Then he must be careful to arrange that he shall have nothing in his mode of living that should be unduly depressing to his heart. He should avoid, as far as possible, overstrain of all kinds—of exertion, hurry, or excitement—and be particularly careful to avoid lowering of his vitality by large quantities of iced drink or very cold drinks. Of course, he should be very careful in regard to all matters of digestion, and only take such foods as are easily digestible. There is, therefore, a great deal that is avoidable and controllable in these cases.

There is another class of case, under which this case does not come, but which all of you must have seen, and will see again, and that is where the trouble arises in the digestive system. There are people who have attacks by day, and others by night. There occurs some serious disorder of digestion, which is capable in one case of producing asthma, in another palpitation, and in another anginoid attacks. Of course, here we have a new aspect, and a very difficult one. It is always very difficult to measure whether the man who has anginoid attacks during the day after exertion, or the one who has anginoid attacks at night as a result of dyspeptic trouble, is in the greater danger. Such cases become extremely dangerous, and the patients very often die suddenly in the small hours of the morning. For the most part they have been eating injudiciously over night, or have impaired their digestion in one way or another.

The curious connection of glycosuria with these attacks has attracted my attention, and I do not know that I can altogether explain it: but certainly I have seen a good many cases in which people who have had angina have also had marked glycosuria. Sometimes the man has come to me for the angina first, sometimes for the glycosuria. Many years ago a clergyman came to me, saying that the doctors had condemned him to death because he had got sugar in his urine. He was not a man likely to die of that, and I was able to encourage him, and four years later he came to me and said: "Now I have got another sentence; I am condemned to death for angina." This was about 10 or 12 years ago, and he is living still: but the curious association of the two things

led me to observe the possible concurrence in subsequent cases, and I have seen it fairly often. Only this morning I had a gentleman to see me who has very sharp anginoid attacks, and who from time to time passes large quantities of sugar in the urine, at other times none.

With regard to treatment, I should be very much inclined to give the patient before us a hundredth of a grain of trinitrin three times a day, with digitalis, for some weeks. I have very often done this, particularly in those people whose hands show the persistent effect of imperfect circulation, and more particularly if such patients have renal disease. I very often use one-hundredth of a grain of trinitrin and five or ten drops of tincture of digitalis three times a day for weeks together, with great benefit. By this means many people have their lives prolonged, and more have their lives made more comfortable. With regard to the treatment of the anæmia, that might fairly be considered; but, considering the patient's age, I should think that the dietary treatment would be better than the administration of iron. One must remember the risk of upsetting the digestion of a person of this age with iron. Brandy is valuable if the patient is very much collapsed, but I should not advise a man to carry a flask of brandy in his pocket. On Sunday morning last a patient of mine came to me in the greatest fright possible, he having had an attack of angina. He had been hurrying to get to church, and he was really very ill. His hands were cold and clammy, and I happened to have some nitro-glycerine, which I gave him; but I also gave him half a wineglassful of brandy with an equal quantity of water, I think with great advantage, although I am now inclined to think that the nitro-glycerine would have acted just as well alone. With reference to the period of administration of trinitrin, I have given it for six months three times a day, in one case at the rate of seven one-hundredths of a grain a day for between two and three months, and with the best result. Of course, in every case the continuance of the dose has to be determined by the effects produced.

I have yet to bring before you another patient who is the subject of heart disease; concerning his case I may be very brief.

CASE II.—There is no anginoid story here. This is a man with apparently permanent shortness of breath after exertion. He has been sent up as suffering from cardiac disease. There is no dropsy, no albuminuria, no enlargement of the liver. He has a very much enlarged

heart and diffused impulse, with a very strongly marked systolic thrill. On listening, one finds that there is a double murmur, a systolic and, I should say, a very strongly marked pre-systolic murmur, ending abruptly, as is usually the case. There is some exaggeration of accentuation of the second sound in the pulmonary area. The pulse is very small, feeble, and very irregular. I should say that this is a well marked case of mitral obstruction with regurgitation.

ON CASES OF ABDOMINAL ANEURISM, VERTIGO, &c.

BY SIR WILLIAM BROADBENT, LL.D., F.R.S.

December 5th, 1899.

GENTLEMEN,—Our first patient is a young married woman, aged 32, presented by Dr. Callender, who gives me the following outline of her history :—

CASE I.—*Aneurysm of the Descending Aorta between Pillars of Diaphragm.*

She enjoyed excellent health until the time of her marriage at age of 22, and has been three times pregnant with, first, a stillborn child at seven months; second, a miscarriage at the second month; third, a puny, weakly infant at full term. Four years ago she suffered from a severe attack of influenza, which was followed by pain in the lower part of the back; two years ago it became much worse, and at Christmas, 1898, the pain was so severe that she was confined to her bed for three weeks. The patient is unable to describe the character of pain with any degree of exactness, merely stating that it is “very wearing.”

Her appetite is now good, but has been very poor; her bowels are regular and her urine normal. Menstruation causes her no pain, and the loss is always very small. Her pulse is 116, large, full between beats, and regular. When walking the patient moves very stiffly and cautiously, in a manner highly suggestive of spinal mischief.

We find a small hyperæsthetic area over the sixth dorsal spine—the tender spot of spinal irritation. On percussion of the posterior surface of the chest a well-defined rectangular patch of dulness is found at the level of the 10th, 11th, and 12th dorsal vertebræ, about $3\frac{1}{2}$ inches in length from above downwards, and extending $1\frac{1}{2}$ inches to the left and $2\frac{1}{2}$ inches to the right of the spine. No pulsation is appreciable over this area. On auscultation a harsh systolic murmur can be heard all down the spinal column, most clearly on the left side, and this murmur is greatly intensified over the dull area. This systolic murmur can also be heard with a considerable degree of clearness when the

stethoscope is placed immediately over the ribs, thus showing that it is propagated chiefly by bone-conduction. With the patient lying on her right side the murmur is intensified on the right of the spinal column.

When the chest is examined anteriorly the apex beat is seen to be displaced downwards and outwards; there is a loud mitral systolic bruit without damage to the first sound. No murmur can be heard in the second right intercostal space or along the course of the ascending aorta.

The case is obviously one of aneurysm of the descending aorta, and the prognosis consequently very grave. It has not yet done what I have once seen in a similar case—dissected off completely one of the crura of the diaphragm, causing paresis of one half of the great muscle.

CASE II.—*Attacks of Vertigo, accompanied by Extra-cardial Murmur due to "Pericardial Corn."*

Our second case is presented by Dr. Dutch, who gives the following outline of his history:—

Mr. J. H., telegraphist, aged 43. Mother died at 58 of hernia; father at 62 of pleurisy. Two brothers: one died in infancy, one now suffering from phthisis; one sister died in infancy. Has always enjoyed good health and never had rheumatic fever, or indeed any serious illness.

Present illness commenced October 14th last with an attack of vertigo while at work, with pains in the limbs. The giddiness passed off the same evening, but he was laid up for two weeks with several successive attacks, usually occurring in the night, and accompanied by pains in the region of the heart with difficulty of breathing; could not "get his breath," and was obliged to sit up in bed.

Returning to work brought on another attack of vertigo and a relapse for another fortnight, but he has now resumed his occupation. A faint cardiac murmur is present, pre-systolic in time, and running over into the systole, but this is not constant.

The first question suggested by this history is as to the nature of the vertigo, whether cardiac, auditory, gastric, or nervous. Examination shows a pulse of high tension, but no enlargement of the heart, a short first sound at the apex, and a murmur more distinct over the right ventricle.

As we listen to this it impresses us more and more as extra-cardial and resembling the "scratch" produced by patches upon the pericardium. If this be its nature it should disappear upon firm pressure, and we find that it does so. So that we may eliminate the heart condition as a cause of his vertigo. If the giddiness were of auditory origin there would be whirling or changes of position of external objects, which our patient does not complain of, also vomiting or purging if the vertigo is prolonged.

By far the commonest form of vertigo is that of gastric origin, especially in nervous individuals, and as our patient admits frequent flatulence and is obviously of neurotic type, his attacks are probably of this nature.

The principal interest of the case lies in the "scratch" murmur, best heard close to the ensiform cartilage. This form of murmur is much commoner than usually believed, and leads to many errors in diagnosis. Many a candidate in the army medical examinations is rejected, quite unnecessarily, on account of just such a murmur. The patches are not the result of any form of pericarditis, show no tendency either to spread or to disappear, and may last a whole lifetime without giving rise to any mischief whatever. In fact, they may be best characterised as "corns" of the pericardium.

CASE III.—*Abdominal Tumour, consisting of Floating Cystic Kidney.*

Our third patient is brought here by Dr. Alfred Phillips, and is a married woman, aged 42 years, mother of twelve children. She has noticed a tumour in the right lumbar region for 12 months past. Upon examination and palpation there is obvious enlargement of the right side of the abdomen, which is caused by a defined, rounded swelling, said to be inconstant. This is apparently the right kidney greatly displaced and highly movable. The tumour easily changes its position both spontaneously and upon pressure.

There is a distinct interval between it and the liver, but it descends sharply upon deep inspiration, which ordinarily a floating kidney would not do. It can be caught between the two hands, deeply pressed into the right loin, and upon careful, deep palpation no kidney in the normal position is to be felt. If the tumour be the kidney, however, it is much enlarged and irregular in its outline, which is explained by

our discovering at the lower and anterior angle of the growth what strongly resembles a group of projecting cysts.

The next thing of importance is to determine the relative position of the colon, as an enlarged and displaced kidney usually carries the transverse colon down with it. If therefore the colon can be percussed in front of and below a tumour at this level, it is strong evidence in favour of its being a floating kidney; and we find the colon here in precisely this relative position.

No report is given of the condition of the urine, and this should be carefully examined, as it is usually abundant and of low specific gravity in a case of floating kidney.

Upon turning the patient upon her side and again palpating, the tumour can be clearly made out to be the right kidney, enlarged, cystic, and much displaced.

CASE IV.—*Case of Rheumatoid Arthritis affecting the Neck and the Joints of the Lower Jaw.*

Our fourth case is a young man who comes to us with the following history :—

Draper's assistant, aged 25; family history unknown. He has always been delicate, and suffered much from "growing pains" as a child. No history of syphilis. Had rheumatism in March, 1896, affecting left hip and subacute in character; the attack lasted for six weeks, and was relieved by the external use of the Bath waters.

He had a second attack in September, 1896, and was an inmate of Bath Hospital for six weeks, and this time the hips, knees, and ankles of both sides were affected. The patient states that his doctor told him that his heart was weak, and that he read on his board "diastolic murmur." His convalescence was tardy and prolonged, and he did not resume work until March, 1897. He was free from any further trouble until June, 1898, when he had another very mild and short attack.

His fourth attack and present illness commenced in July, 1899, and on this occasion his hands and elbows were affected, in addition to his ankles, knees, and hips. Scarlet fever supervened on July 24th, and his hands became swollen and paralysed, though there was no loss of sensation. He was treated in the Western Fever Hospital at Fulham,

and on September 19th pronounced convalescent and removed to the Northern Convalescent Hospital. On September 22nd he first felt pains in his back, to use his own expression, "as if he had been kicked all over," and when he awoke on the morning of the 28th he felt his jaws and neck were stiff, and his head was rotated towards his right shoulder and fixed in that position.

On examination traces of old rheumatic thickening are plainly visible about the fingers and wrists; his ankle and knee joints are freely movable and give no pain, but considerable pain in the hip joints is caused by forced adduction of the thighs when flexed on the abdomen. He can raise himself from the recumbent into the sitting posture only with very great difficulty, performing all movements which necessitate even the slightest degree of spinal rotation with much caution and very stiffly. His head is turned towards the right shoulder and rigidly fixed in that position, the cervical muscles of that side being in a state of tonic contraction.

He is unable to open his mouth to a greater extent than is sufficient to permit the insertion of the tip of the finger. Examination of the heart reveals the presence of a faint mitral, systolic murmur, but the second sound is not affected, and the heart is not appreciably enlarged or the apex beat displaced. His pulse is 82, regular, and of moderate tension. The reflexes of the lower extremities are much increased, especially so on the left side, and here ankle clonus can be elicited.

The nervous symptoms should probably be regarded rather as a functional disturbance than as evidence of any organic mischief, and with good food, rest, and proper nursing, the prognosis is favourable.

ON CASES OF MYXŒDEMA AND BULBAR PARALYSIS.

BY SEYMOUR TAYLOR, M.D., M.R.C.P.

October 24th, 1899.

GENTLEMEN,—The first case which is brought to our notice is one of Myxœdema. I must at the outset tell you that the nomenclature is Dr. Ord's, whilst Gull, who first drew attention to the disease, called it "a cretinoid condition supervening in adult women." I think we might with all fairness label this triumph of British medicine as "Gull and Ord's disease."

You will remember that the disease is characterised by slowness in cerebation, in speech, and in muscular movements, and by noteworthy dystrophies of the skin and its appendages, all of which are brought about by the atrophy or histological destruction of the thyroid gland. That the pathology is correct has been proved in three different fields of scientific research—by Kocher, who saw the disease develop after operating on thyroid enlargements; by Horsley, when he produced myxœdema in the sheep by ablation of the gland; and lastly by Ord, who conducted extensive pathological and clinical researches.

And here let me diverge for a moment to point out to you, as I was wont to point out some years ago to students in the anatomical rooms, the obvious importance of the thyroid body, if only judged from its vascular supply. Every neighbouring trunk-vessel seems to go out of its way to supply this little organ. The superior thyroid artery comes down from the external carotid, the inferior thyroid runs back from the axis of the subclavian; the innominate artery occasionally sends a branch; nay, even the arch of the aorta itself would appear to be under some responsibility for its vascular supply, if other sources failed. The importance of this little gland, predicted by its peculiar and unusual vascular supply, is emphasised by the symptoms which are produced by its destruction. Here, in parenthesis, I must warn you of the difficulty in feeling not only a wasted thyroid gland, but even a healthy one. My experience is that it is almost an impossibility, owing to overlapping muscles, to feel a normal thyroid body, except the patient have a very thin, spare neck.

Now for the clinical side of the question. The disease occurs for the most part in women, in the proportion of quite five to one of men. The face has a typical character. One notices at once the marked flush on the cheeks, and the areolæ of comparative pallor round the mouth and eyes. The lips are pendulous and devoid of the finer movements of expression and labial speech; the voice is leathery or grunting in quality; the tongue is swollen. In addition, the skin on the hands is harsh and furfuraceous; the hair has fallen, especially from the scalp, where the parting is consequently broad or ragged; the teeth are nearly all shed; cutaneous sensation is blunted. The hands are rude instruments, with boorish expression, and no longer deft or supple; supra-clavicular masses of fat are not uncommon.

As the disease advances there may supervene muscular paresis; hæmorrhages are not uncommon, whether from the bowel or vagina, or from the gums; or it may be that they occur in large patches subcutaneously on the buttocks or hams or elsewhere.

Finally, neuroses may occur, in one case taking the form of melancholia, in other of mania or delirium, in a third of unwarrantable suspicions.

From beginning to end of the disease the urine is free from albumen, or, if present, it is a concomitant condition or accident, and is in no way related to the production of the symptoms of this remarkable disorder.

The treatment of the disease is now singularly successful. Formerly jaborandi, arsenic, and other drugs were prescribed with little or no permanent good. But since Dr. Hector Mackenzie showed us the way by administering the thyroid body of a sheep, our cures of this disease have been remarkable. Some of you may practise in countries or towns far removed from a first-class chemist, and the thyroid tablet may be therefore a medicament not easily or quickly to be obtained. To such practitioners I would advise going at once to a butcher's shop to purchase a sheep's windpipe. The thyroid gland is easily exposed by raising the sterno-thyroid and the sterno-hyoid muscles, when it is found lying on the side of the thyroid and cricoid cartilages. Each lobe is about the size of an almond, and there is no isthmus to connect it with its fellow. Having taken out the gland, you may form a mince by chopping up one lobe, and then this is to be smeared on bread and butter and eaten as a sandwich. You may repeat the dose in three or four days, so that the patient has one entire gland a week.

In about six or eight weeks the results of this treatment are marvellous, and I propose to show this patient again to you, when the effects of the remedy will be patent to all. I am rather inclined to the opinion that this form of administration is superior in its results to those effected by tabloids.

Case of Bulbar Paralysis.

The next case which I show you is a very rare one, and was sent to me by my colleague, Mr. Keetley. It is a case of bulbar palsy, due to sclerosis, most probably, of the medulla oblongata. The patient is a powerful man of about 48 years of age, and is a fisherman by occupation. There is no history of syphilis, nor of shock, nor of mental anxiety; but there is a distinct history of rheumatism, and on one occasion he underwent great exposure, whilst on the sea.

As you will see, the patient's expression is somewhat vacant, owing to his pendulous lips, and saliva easily dribbles from the corners of his mouth. The tongue is raised from the floor of the buccal cavity with difficulty and slowness, and when protruded, which occurs only after an effort, it is seen to be markedly tremulous, the tremors being of a fine or fibrillar type. His speech is peculiar; he has no true aphasia, yet it is difficult to understand what he means, owing to loss of power of movement and of co-ordination in the tongue muscles, and his intonation is grunting in character.

Deglutition is slow, and has to be carried on with care and effort lest the bolus should "go the wrong way." Although the buccinator muscles are intact, the pterygoids are involved, and the grinding action of the jaws is performed with some difficulty. The palate reflex is not lost, nor does he at present show any signs which would suggest serious involvement of the vagi centres.

In order to distinguish this case from one of general paralysis of the insane, I would point out that (1) he has no irregularity in the pupils; (2) that ordinary tactile sensation is unimpaired; (3) that his mind is quite clear.

The outlook is unfortunately gloomy; but my colleague, Dr. James Taylor, has suggested that the hypodermic injection of strychnia might afford some relief or retardation of symptoms.

ON CASES OF PITYRIASIS RUBRA, DRUG ERUPTIONS, &c.

BY MALCOLM MORRIS, F.R.C.S.

December 4th, 1899.

GENTLEMEN,—I show you to-day a child of 4 years of age who appears to be affected with that interesting condition, pityriasis rubra. The skin of the face and hands is, as you see at a glance, reddened, very slightly thickened, and covered with patchy scales, with shining lines along the flexures, almost approaching to fissures. On looking closely at the skin of the lower lids you will see that it is parchment-like, and that the lid itself is apparently beginning to be stiffened and slightly retracted. As the clothing is removed you see, that what is true of the face is true of the entire surface of the body; trunk, arms, legs, and feet. The nails are thickened, opaque, and longitudinally ridged, but none of them have been lost. There is so much heaping up of epidermis that the first glance almost suggests ichthyosis, but upon pinching up the skin between the thumb and finger you find that it is quite flexible, and that the thickening is for the most part only apparent. The scalp is full of a paste-like mass of scales, the hair is matted together, and the whole skin has a curious, tense, and slightly shining appearance, as if it were too small for the body.

The first trace of the affection noted by the mother was a few small rough, scaly patches upon the nose, which appeared when the child was about 7 months old. These rapidly spread over the face, into the scalp, and then down the back and breast, so that in about 18 months' time the eruption had become practically universal and has remained so ever since. Fortunately, the child's general health has remained unaffected, she is well grown and vigorous, and this marks a striking departure from the extreme depression and toxæmia which in some cases accompanies this disease in the adult. The condition has greatly improved, during the past three months, under the local use of lanoline and oils.

The question of the origin of pityriasis rubra is one of the most puzzling in dermatology. It may apparently occur in the course of almost any acute and widespread cutaneous affection, whether eczema, psoriasis, lichen planus, erythema multiforme, or even from direct

irritation from drugs. I recall one severe case which began as lichen planus, and in which the flat-topped shining papules of the lichen could be seen for some time projecting up from the universal reddening. In another case it followed erythema multiforme, and here the general symptoms were so intense that the patient became delirious, insane, and finally died in coma.

One of the most singular cases I have ever seen was due to a drug eruption. A servant girl, about 17 years of age, was brought into the hospital with a few small patches of psoriasis in the typical situations. An ointment of chrysarobin was prescribed, and the first application was followed by a fierce attack of inflammation all round the patches, which rapidly spread over the entire body, accompanied by high temperature and severe malaise, and resulted in the shedding of the horny layer over the entire body, including the complete loss of the hair and nails. She was weeks in recovering from the attack, and then from a single dose of quinine, given as a tonic, a severe relapse was brought about, with repetition of the previous symptoms, and even more profuse desquamation, and before she fully regained her normal condition she had two more recurrences. The skin finally cleared up completely and remained healthy for some seven or eight years, although the girl was greatly changed in her appearance, but symptoms of a return are showing themselves during the past few weeks.

As to the actual nature of the disease we are equally in the dark, the character and severity of its general symptoms apparently pointing towards some form of intestinal toxæmia, and, indeed, among internal remedies the intestinal antiseptics appear to give the most relief, although we can hardly claim that any one remedy has a marked effect. No doubt part of the toxic symptoms are due to the extensive impairment of the excretory functions of the skin. Indeed, it seems possible that pityriasis rubra may not be a distinct disease entity at all, but an extreme stage in the development of a variety of skin diseases. The extraordinary number and variety of diseases from which it may apparently originate would certainly point in this direction, though it must be admitted that it also appears as a substantive disease.

The next case is one of pruriginous eczema, closely resembling the celebrated prurigo of Hebra, of 28 years' standing, in a woman of 59. As you see, the backs of her hands, wrists, and forearms are thickly covered with small dusky red, elevated patches which itch excessively

and show the excoriations and scabs due to violent scratching. The skin of the palms is dry, shining, and somewhat thickened, and as I find upon enquiry that this has always been the character of the hands and arms since her earliest recollection I am inclined to think that we have here a congenital defect of the skin of the nature of xerodermia. The skin in places is almost parchment-like, and shows distinct, leathery creases at the flexures of the wrists and elbows. She gives a history of an itching eruption first appearing upon the hands and wrists in the hot weather of summer, and for a number of years clearing up completely at the approach of cold weather, evidently a form of the "summer prurigo," of which Mr. Hutchinson has reported so many cases. As the disease has continued, however, it has grown gradually more and more severe, and the winter intervals shorter and shorter, until now it has become constant. The furious itching is interfering with her sleep, and her health is becoming affected in consequence. The feet and legs are found to be in almost exactly similar condition to the arms, and the glands in the groins, armpits, and neck are enlarged.

The prospects of treatment, in this class of cases, are of course anything but encouraging, as their principal characteristic is their extreme obstinacy and resistance to every form of therapeutic agent. So widespread and intense is the irritation, that we are obliged to attempt to control it by systemic remedies, in addition to such local applications as experiment shows to be of value in each particular case. This is specially necessary where, as in this case, the sleep is being seriously interfered with, but unfortunately our sheet anchor for the relief of pain or irritation, opium, suits badly in these cases, even seeming to increase the restlessness. There is, however, one drug which at times works admirably, but can only be recommended for a trial in each particular case, and this is belladonna in small doses. The bromides are often of the greatest assistance, but, like the others, they completely fail to affect many cases. The local remedies should, of course, be protective and sedative, and of these I find the old-fashioned calamine lotion, combined with tar, to give relief in the largest proportion of cases. In some cases of this summer prurigo much irritation appears to be due to the direct effect of light, and in these, thick salves or pastes, which will exclude both air and light, are of great benefit, and their efficiency will often, curiously enough, be greatly increased by

the addition of some colouring material which will further protect against the irritating light rays. For this purpose I have found some vegetable pigments used by actors in their make-up most serviceable, notably "bole Armenian," a few grains of which to the ounce will give a dark red colour to the salve, and remarkably increase its soothing and protective properties in some of these cases.

The next patient is a man of 40, in vigorous health and, as you see, covered from head to foot with a most profuse and striking-looking eruption. This is emphatically a consultation case, inasmuch as the chief interest is the question of diagnosis between those celebrated rivals, psoriasis and seborrhœic eczema. At first sight one is tempted to make a diagnosis of psoriasis, for the whole trunk and scalp are covered with round, scaly patches about the size of a sixpence, upon reddened bases, matting together among the hairs of the head into a dense, mortar-like mass, a typical picture of the old psoriasis nummulata, but, upon questioning and examining more closely, our confidence becomes somewhat shaken, for the whole eruption has developed within the past month, and it began in the scalp, and from that spread down back and chest in the familiar "scurf-dropping" manner. Moreover, his knees and his elbows are almost completely free, neither arms nor legs are at all so extensively affected as the trunk, just as would be expected if it were a seborrhœic eczema spreading from the scalp, as they are farthest removed from the source of the infection. Further, the flexures of the neck, groin, and armpits are profusely affected; so that the case is admirably adapted to divide my audience at once into two hostile camps, each confident of the correctness of its diagnosis; and now that you have had the opportunity of examining him and considering the pros and cons, I find, as I expected, that you are almost equally divided in opinion. It is suggested that we should apply chrysarobin to some part of the eruption as a means of assisting to settle the question of diagnosis but I should hesitate about doing this, first, because either disease would be benefited to some degree by the application; and, secondly, because in cases of such rapidly spreading character I should be afraid of setting up an undesirable amount of reaction by such an active irritant. This is just the type of case in which from a comparatively mild application we may get some of the most alarming forms of chrysarobin poisoning.

As for my own opinion of the case, some patches are so strikingly characteristic with their red bases and silvery scales that I am inclined to regard the disease as acute psoriasis, in spite of its untypical history and the gaps in the clinical picture. I shall begin with an application of weak tar ointment, and shall reserve the more potent but irritating remedies like chrysarobin for a later resource, although I sha'l expect to see rapid improvement under the use of tar.

ON A CASE OF SUPPOSED SYPHILIS IN THE THIRD GENERATION.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—I wish to-day to offer additional facts respecting a case brought before us last week in which there was *primâ facie* suspicion that syphilis had been transmitted to the third generation. The facts respecting it I have since carefully investigated, and the results are very important. You will remember that amongst the cases presented at my last demonstration were a mother and child. I had not seen them before and knew nothing of their history. It was, however, easy to see that the child, a stout infant of eight months, was suffering from inherited syphilis. It had a sunken bridge of nose, sores at the angles of mouth, a circinate eruption in small patches about its wrists, and, above all, a large ulcerated condyloma on one side of its anus. Whilst looking at the child I observed that its mother also bore in her physiognomy the well-known features of inherited taint, and on enquiry was told that she had, at the age of 17, passed through a severe attack of inflammation of both eyes. She had one characteristically notched tooth, and putting all these facts together, I felt no hesitation in expressing, without reservation, the opinion that she had suffered severely in infancy from inherited syphilis. She was a woman of about 32, and had been married 10 years. She told us that she had borne six children, and that her first-born, now a boy of 9, was living, but that in his infancy he had presented symptoms which were exactly like those now present in her baby. Between the two there had been four premature births, all dead. The woman considered that both she and her husband had enjoyed good health, excepting that the latter suffered from asthma. No further questions were asked. Having stated to those present my confident belief that we had had before a most unquestionable instance of a mother, herself the subject of inherited taint, who had borne a tainted child (or probably two), I avowed my incredulity as to the infant's inheritance from its mother's inherited taint, independently of subsequent acquisition by one or other parent. If inheritance in the third generation were a possible occurrence it ought, I contended, to be a tolerably common event, whereas the instances in which it has been

suspected are exceedingly few. From my own experience I mentioned several in which the known subjects of inherited taint had borne quite healthy offspring, and said that I had only met with one single instance like the case before us, whilst in that one it was probable that the father of the infant had had the acquired disease. On *à priori* grounds the improbability of transmission to the third generation appeared, I ventured to remark, almost infinitely great. Finally, I promised that all the facts should be carefully examined and the patients brought forward again on some future occasion.

The patients had been sent to me by Dr. Sharman, of Dulwich, and I at once communicated with that gentleman in order to ascertain whether he knew anything of the family, and whether he could procure me an interview with the father of the child. Through Dr. Sharman's courtesy the father, mother, and both children were sent a few days later to my private residence, and subsequently they were induced to attend again at the Polyclinic. Dr. Sharman wrote me that he had himself thought that the mother showed the physiognomy of inherited taint, but of this suspicion I had previously heard nothing.

When the family attended at my house I first inspected the elder child and found that he had a most characteristic physiognomy and equally characteristic teeth. He had not, as yet, suffered from keratitis, but his mother's statement that he had presented the usual group of symptoms in infancy was well borne out. He was a well-grown, cheerful boy, but his teeth bore evidence of his having taken mercury in infancy. He had attended many months at the Great Ormond Street Hospital for Children.

My next step was to see the father alone, and having assured him that I would say nothing to excite suspicion in his wife, I begged him to tell me candidly whether he had before marriage suffered from venereal disease. He assured me most positively that he had not, and he spoke with apparent truthfulness. There was nothing I could observe in him to invalidate his statement. He said that he had suffered much from bronchitis and asthma, and the ends of his fingers presented the broad nails and clubbed form of the pulmonary type of acromegaly. I may own that at the time I believed what he told me, but I subsequently found that a similar question had been put to him by Dr. Sharman, so that he was prepared for mine, and no doubt felt bound to adhere to what he had first said.

Next I saw the woman alone, and having obtained from her an account of her childhood, which confirmed what has already been stated, but with the addition that she was the eldest of six living brothers and sisters, all the others being in good health, I enquired as to her own health since her marriage. I gave her no leading questions, and endeavoured carefully to avoid exciting her suspicion as to what I wanted to know. She said that she had always been well, but then added quite spontaneously, but in a manner which made me feel sure that she knew what she was telling me: "I once attended University Hospital for sores." "When was that?" "Oh! as soon as I got up from my confinement with my first child." "Where were the sores?" "On my privates." "Did they examine you at the hospital?" "Oh, yes." "And what did they give you?" "Powders." "How long did you attend?" "Oh, almost six weeks; I was soon well and never had anything since." I have given you the *ipsissima verba*, because here ended this important episode. The woman would not admit that she had suffered from any eruption or sore throat, and I had promised her husband that I would ask no questions which should lead her to entertain suspicions of him. Had I put any direct questions to her very probably she would have denied everything. At the same time I feel quite sure that she intended me to take the fact for granted. She could have had no other motive for mentioning the occurrence at all, for she denied that it had affected her general health.

My own interpretation of the case is that in all probability the husband contracted syphilis during the latter part of his wife's first pregnancy, and infected her, and through her their child. On this hypothesis the facts prove conclusively that a tainted mother may bear a tainted child at least seven years after her acquisition of the disease. This is in itself an important fact, but it has been repeatedly proved before, and it is as nothing compared with the hypothesis that a mother, herself the subject of inherited taint, may bear tainted children as the result of such inheritance. In support of that hypothesis the case cannot for a moment be quoted, for although it may be admitted that the acquisition of syphilis *de novo* by the mother is not conclusively proved, enough evidence has been offered to make it very probable, and to entirely prevent the case from being cited as proof of anything else.

In conclusion, let me beg you to note how very near we have been to missing the truth in the history of this case. If the mother had not at

the last minute volunteered the information which she gave, we should have been obliged to record the case as one in which syphilis had occurred in the third generation, and in which there was no reason to suspect the acquired disease in the parents. The literature of syphilis, let me say, abounds in cases in which errors of this kind have occurred. We are obliged to record our patients' denials, and if we can find no reason for disbelieving them, we are obliged to give them a certain amount of credit. In this instance, as you heard, the father of the child strongly denied having had any disease, and there were no facts by which to confute him. He appeared to be healthy and so did his wife. As regards his denial, we must remember that he had been asked the same question before I saw him. In these cases everything depends upon how the question is put on the first occasion. If a man has once said, "I never had anything of the kind," he cannot well go back on himself, and admit that he has told a falsehood; I have known that done, but not often. Now, when something happening to a man's offspring is in question, a father is under a great temptation to exculpate himself. Not unfrequently, on the impulse of the moment, an emphatic denial is given which would willingly be retracted afterwards could it be done with dignity. As regards the mother, I do not think that she would have made any confession to me had I asked her in the presence of others. It was only because she was speaking to me in the privacy of my own study that she became confidential. I feel really thankful to her for the information which she gave me. Had she not given it, I should have felt compelled to publish the case as one which, so far as I could ascertain, supported the doctrine of third generation transmission. In that doctrine I am no believer, but there are those who do believe it, and the case would have been triumphantly cited by them as a most conclusive one.

NO. II.—ON MERCURIAL TEETH.

I have long taught that it is easy, in any case in which a full set of the permanent teeth has been cut, to tell whether the patient has taken mercury in infancy. A guess may also be made as to the exact age at which the mercury was given. The first molar is the tooth to look at, and its condition should be contrasted with that of the two bicuspids in front of it. If the latter are white and sound whilst the molar is defective as regards its enamel, and is either destroyed by caries, or

shows projecting spines of exposed and discoloured dentine, then it is almost certain that the enamel organ of the tooth was damaged by alveolar congestion in infancy. This tooth is the first of the second set to calcify, and is therefore the most in risk of damage by mercurial stomatitis in very early infancy. Simultaneously with it, the canines and all the incisors frequently escape, whilst the two bicuspid almost always escape. If the mercury be given late in infancy, during or after the second year, then the first bicuspid may suffer also, but the hinder one almost invariably escapes. I have had many opportunities for demonstrating these points at the Polyclinic, and long experience has convinced me that they are trustworthy.

NO. III.—ON ICHTHYOSIS HERPETIFORMIS, OR BIETT'S BANDS.

The reader must imagine a fat, chubby child of a year old, whose thighs look as if marbled with thin mud, and upon whose abdomen and neck are large patches which suggest simply the need of soap and water. So exact was the resemblance to dirt that I did not at first glance feel certain, and asked the mother if the streaks and patches could not be washed off. Critical inspection, however, led to the observation that one streak ran vertically up the middle line of the abdomen from pubes almost to navel; that there was a collar all round the neck, from which another vertical band wholly confined to one side ran up to the chin. The use of a glass showed also that the mud-streaks were slightly papillary in places and a little raised. This was more especially seen on the back of the child's neck.

I asked attention to the fact that, although many of the streaks and patches were bilateral and almost symmetrical, there were yet very marked deviations from symmetry. This was especially the case in the vertical bands, which ran up just on one side of the mid-line of the trunk but did not transgress it. These vertical bands were quite characteristic of the affection, and enabled us to place it without hesitation amongst the congenital defects in the development of the skin to which the term "Ichthyosis" has been given. The peculiarity of the case consisted in the fact that the changes were so very insignificant in amount. The mud-column did not depend so much upon pigmentation as upon a slight alteration in the surface of the skin, which rendered it prone to accumulate particles of dirt and very difficult to wash. In more advanced cases the skin becomes rough with dry

papillary outgrowths, and these are always almost black with dirt, which it is impossible to remove. Although usually classed as a form of ichthyosis, constituting the form known as ichthyosis hystrix, and including such cases as the "porcupine man," yet, it was, I remarked, quite different from the diffuse forms of that malady; its tendency to arrangement in streaks, and its invariable deviation from bilateral symmetry, being conspicuous features of distinction. These bands, although never accurately following the distribution of nerves, yet often bore a superficial resemblance to those of herpes zoster, and had suggested the name of Ichthyosis Zosteriformis. From the name of the French surgeon who first described them they had been named Bielt's bands. The unaffected portions of skin remained perfectly healthy, a condition never observed in the other forms of ichthyosis. In the commoner forms of diffuse ichthyosis or xerodermia almost always more than one child in the family is affected, whereas in this never more than one. In the present instance a very peculiar condition of the scalp, and one which I have not before observed, was present. The hair was much thinner in some parts than others and also of a paler tint. The arrangement was in bars of about a finger's breadth, which curved round the head; nowhere was the hair quite absent, but bars of strong and rather darker coloured hair alternated with others in which the hair was thin and weak. As the child was an infant, it was impossible to say whether the thicker hair or the thinner was the more normal. Had the whole head of hair been alike in either type it would have ranked as quite natural.

I remarked that these examples of congenital bands and one-sided patches were to be considered together with certain conditions sometimes observed in the domestic animals. Both cats and dogs sometimes show them, a straight line of demarcation or column running right up the face of the animal. They prove that the two halves of the body have some slight independence of each other and of central influences in their development.

As regards treatment it was advised to allow the child to grow up and then to destroy any patches which were disfiguring by light applications of the actual cautery. It was easy, I remarked, to get rid of them, and the papillæ were never reproduced.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

OPHTHALMOLOGICAL CASES.

BY E. TREACHER COLLINS, F.R.C.S.

October 13th, 1899.

CASE I.—*Pulsating Tumour of Orbit following Injury by a Revolver Bullet. Position of Bullet located with X-rays. Ligature of Common Carotid. Return of Pulsation.*

ARTHUR K., aged 34, 13½ years ago was shot with a revolver just beneath the lobe of his left ear. He was treated at a hospital for a week, when the wound having healed he was discharged. Two years later his left eye gradually began to protrude. It has remained in this protruded condition for 11 years, the amount of prominence varying from time to time, becoming decreased when he remains quiet, and increased when he has been moving about. When most prominent, he sometimes gets attacks of bleeding from the left nostril. Ever since the accident he has had a buzzing noise in his head.

He attended first at the Moorfields Hospital, on February 6th, 1899. On examination his left eye was seen to be markedly proptosed, there was fulness of the eyelids, especially the upper, and an irregular prominence extending to the side of the nose. The movements of the globe were restricted to upwards and outwards, and there were enlarged conjunctival vessels on its surface.

On palpation, a pulsating tumour, with marked venous thrill, could be felt above the globe. The pulsation in it ceases on pressure of the left carotid, which diminishes the size of the tumour, the amount of proptosis, and the buzzing noise in the patient's head.

Vision of right eye = $\frac{6}{6}$, of left = $\frac{6}{18}$; it is improved slightly after pressure on the carotid.

Ophthalmoscopically the left optic disc was seen to be pale, and the retinal vessels small.

Skiagraphs with the X-rays were taken of the patient, by Mr. Mackenzie Davidson, showing clearly the presence of a bullet, which was located by him as lying outside the skull, just beneath the basilar process.

The patient was admitted into the Moorfields Hospital, and on February 20th digital compression of the left carotid was kept up for $6\frac{1}{2}$ hours by relays of assistants. The amount of pulsation afterwards seemed less marked. Three days later compression was kept up for another $4\frac{1}{2}$ hours. The improvement resulting from this treatment was so slight that it was decided to ligature his left common carotid. This operation was performed upon him at the London Hospital in March by Mr. Openshaw.

The immediate effect was complete arrest of pulsation, diminution of proptosis, and cessation of the troublesome buzzing noise in the head. This lasted for about a month, and then the symptoms began to return, but at the present time the proptosis is not so marked, nor the noise in the head so intense as it was previous to operation. A pulsatile thrill is now most felt in a prominent part of the swelling at the side of the nose. All pulsation and the noise in the head can be arrested by compression of the carotid on the right side. No further treatment advised at present.

December 8th, 1899.

CASE II.—*Rupture of Eye, with complete Escape of Iris and Lens, caused by a Blow.*

GEO. H., aged 42, stated that on October 2nd he received a blow on his right eye from a fist; he went to a hospital and was kept there for two months, but no operation was performed. On examination of his eye no iris could be seen, a dull red reflex was observed over the whole of the area occupied by the cornea, causing the eye in certain lights to glow like a dim bull's-eye lantern. On throwing reflected light into the eye with the ophthalmoscope mirror numerous floating opacities were seen, but no sign whatever of the lens. The periphery of the red reflex was bounded in all directions by a notched margin, evidently due to the ciliary processes having been exposed to view. The details of the fundus were seen best with a + 10 D lens behind the ophthalmoscope, but they were indistinct on account of the vitreous opacities. The most careful examination failed to detect any portion of the lens or iris in

the eye. Examination of the external surface of the globe showed a dark line in the sclerotic round to the upper and inner margin of the cornea, about 2-3 mm. distant from it, and extending round about one-third of its circumference. It was in all probability the line of a rupture through which the lens and iris had escaped.

Tension was normal: V = fingers at 6 inches.

Several cases are now on record of escape of the lens through a ruptured sclerotic, under the conjunctiva, where it is rapidly absorbed, but loss of the iris in this way is decidedly rare.

CASE OF GOUT.

Large Tumour of Left Ear: Tophi in the Site of an Old Hæmatoma.

JAS. MCG., aged 58, presented himself at Dr. Ord's consultation, November 27th, with a swelling in the tip of his left ear of the size of a half walnut. The helix was soft and leathery to the touch, but contained three or four hard rounded masses of the size of a pea, two of which gleamed white through the purple skin. He had been an outdoor porter, lived a life of much exposure, and drunk hard. About 30 years ago he received a violent blow on the ear during a boxing match which resulted in a small hæmatoma. Fifteen years later he came into the Westminster Asylum with a sharp attack of gout of the left great toe, and since that time has had between 20 and 30 attacks extending to the hands, wrists, ankles, elbows, and knees. These usually come on after a drinking bout, and lay him up for from two to six weeks. The last one occurred seven weeks ago, and attacked chiefly the bursa over the olecranon, which is still much enlarged and full of hard, knotty, rounded masses, probably fibrous tophi.

He has had a number of attacks of pain, heat, and swelling in the tumour upon his pinna, each one leaving it harder and slightly larger. Colchicum has always promptly relieved his arthritic attacks. His urine is free from albumen, his arteries fairly elastic, and his heart sound.

The principal interest of the case is as an illustration of the influence of traumatism upon the localisation of tophi.

CASES OF SKIN DISEASE.

DEMONSTRATED BY ARTHUR WHITFIELD, M.D.

I. *Three Cases of Lichen Planus.—Improvement in Two under Arsenic.*—

(a) The first case was a generalised and, indeed, almost universal eruption. The patient was a man, aged 60, a dealer in mineralogical specimens by trade. The eruption had appeared about two years before on the chest, and had rapidly spread all over the body and extremities. When shown the whole of the trunk was covered with a dark red scaly eruption, in which it was almost impossible to make out any of the typical papules of the disease. On the limbs, however, the curious network of angular papules was very definite. The palms and soles were very much thickened and scaly, and the scalp was also diffusely desquamating, while the hair was a good deal thinned. The mucous membrane of the lips, mouth, and throat was covered with bluish-white papules. Treatment had been entirely unsuccessful, the patient having taken large quantities of arsenic, perchloride, and biniodide of mercury, and salicin. The greatest relief seemed to be afforded by rubbing with a weak sulphur and salicylic acid ointment. Some members of the class suggested antimony internally, but after a six weeks' course of this no improvement either in the subjective itching or in the appearance of the rash could be reported.

(b) A case where the disease occurred in nummular patches on the arms and legs. The papules were again ill-defined, but the diagnosis was arrived at by the examination of the patches with a lens, revealing individual lesions, by the great infiltration, and by the peculiar violet-red colour and mother-of-pearl gloss. This case rapidly improved under arsenic.

(c) A case where there was linear streak about $1\frac{1}{2}$ inches broad running down the front of the left shin from the knee nearly to the ankle. The papules were well marked, and there was no difficulty about the diagnosis. Improvement took place slowly under arsenic.

II. *Ulcerating Purpura following Scarlatina—Recovery under Turpentine.*—This case offered some difficulty at first, owing to the fact that those lesions which had not ulcerated had faded when first seen. There was still left, however, some brown pigmentation, marking the

sites of the old eruption. When the disease first appeared it apparently affected all the extremities, but latterly it had been confined to the legs. The ulcers were small and very indolent, being situated round the ankles and on the dorsa of the feet. The rash had appeared soon after an attack of scarlatina, in which the joint symptoms had been so severe that the diagnosis of acute rheumatism had been made. The patient recovered under turpentine internally, combined with rest in the horizontal position, and careful dressing of the ulcers with boric acid ointment.

III. *Dermatitis Venenata, due to Ivy.*—This patient was a gardener, and suffered from the eruption about a week after nailing up and trimming Irish ivy. The symptoms were intense itching and burning of both arms and hands, followed by the appearance of an erysipelatoid blush, on which thick-walled vesicles were formed. On careful examination it could be seen that these vesicles ran in lines according to the manner in which the twigs had scratched the skin. The whole eruption calmed down in a week under calamine lotion.

IV. *Extensive discoid Lupus Erythematosus, extending to the Back of the Head.*—The patient was a woman between 50 and 60 years of age, and had suffered from the disease for 10 years. When shown she had several discs, about the size of a florin, on the face, many of which were scarring in the centre. All had deep red infiltrated margins, and some showed no tendency to involution. Both ears were affected, but inside the concha, and not at the free edge as is usually the case. The whole of the back of head was a vast scar owing to the ravages of the disease, and was of course perfectly bald. The edge of this scar was still reddened and actively progressing when first seen, but had now quieted down. The patient had been treated with lotio calaminæ as a temporary measure, and so much improvement had taken place that it had not been changed for anything more active.

V. *A Case of Rhinophyma—huge Three-Lobed Tumour of Nasal Tip.*—The patient was a linoleum-layer, and had always been temperate. For the last several years his nose had been gradually swelling, until it had lately reached its large size. The end of the nose was very blue in colour, and over it large veins could be seen coursing, the sebaceous gland orifices being also greatly enlarged. There were three main lobes

to the tumour, one corresponding to each ala, and one to the point of the nose. On moving these aside two small secondary lobes could be seen lying in the folds between the large lobes. The patient was taken into the Great Northern Central Hospital; the tumours were to be dissected off and the base allowed to heal. Dr. Whitfield pointed out that, owing to the depth to which the ingrowth of normal epithelium reached in the tumours, Thiersch grafting would be unnecessary.

VI. *Simple Leucodermia in a Girl*, affecting the back of the neck and posterior part of the scalp, thus producing canities of the back hair; also affecting both arms on the flexor surfaces.

VII. *Acute Guttate Psoriasis supervening on old Chronic Patches of nine years' standing*—*Clearing up of both Eruptions under Creosote and Tar*.—The patient was a girl, aged 17, who had had chronic patches of psoriasis on both knees for nine years. Six weeks before exhibition she had suffered from a sudden outbreak of acute papules all over the legs, arms, and chest. Heaping up of the scales was very marked, both in the old patches and in the new. The exhibitor drew attention to the fact that, when coming out acutely, psoriasis did not always keep to the extensor surfaces, as was illustrated by this case, in which the flexor surfaces were quite equally, if not more severely, affected. The patient was treated by the administration of creosote internally, with only a weak (2 per cent.) lotion picis carbonis externally when the rash itched. In six weeks the rash had entirely died away, and the chronic patches of nine years' standing had also disappeared. On leaving off the creosote there was a tendency for the rash to reappear.

VIII. *Three Cases of Syphilis*.—

(a) *Impetigo-like Syphilide on the Nose, with Gummatous Node on the Forehead*.—The patient was a man who had had syphilis 18 years previously. On the left side of the nose and at the left angle of the mouth were two small crusts of about the size of a lentil. They looked, indeed, quite innocent at first, but on closer examination it was seen that there were two or three small scars in their neighbourhood. On removing the scabs it was found that there was true ulceration beneath, and that there was a good deal of induration at the edges. A further search revealed a node, the size of half a cherry, in the middle of the forehead, and a ring-shaped patch of gummatous nodules in the middle of the

back. The patient had not undergone regular treatment, and was therefore put upon mercury, under which everything cleared up.

(b) *Late Papular Syphilide of the Nose and Scalp, producing Swelling of Nose-Tip, resembling Rhinophyma*.—In this case the nose was so swollen and blue that the diagnosis of rhinophyma had been made. The swelling was, however, made up entirely of large, indolent, indurated papules of a coppery colour. The scalp was covered with similar, but still larger, lesions, and almost all the hair had fallen as the result of the inflammation. All the infiltration cleared up under anti-syphilitic treatment, but some atrophy of the scalp was left, and permanent alopecia.

(c) *Sycosiform Syphilide on Upper Lip*.—The patient came on account of a scabbed condition of the upper lip under the moustache. On removing the scabs, it was found that the whole of the upper lip was deeply infiltrated and covered with pustules. The pustules did not seem, however, to correspond with the follicles very accurately, and while examining the lip it was noticed that there was some thickening of the mucous membrane. An examination of the mouth showed multiple shallow ulcerations, and a search over the whole body showed two patches of serpiginous cutaneous gummata, on the right scapula and right deltoid respectively.

IX.—To compare with this case, a well-marked case of old sycosis of staphylococcic origin was shown. In this man the disease also affected the upper lip, and had caused so much scarring of the red portion, that syphilis was at first suspected. No trace of specific lesions was to be found, however, and the disease was of 12 years' duration, beginning in the left eyelid. At the time of demonstration both eyelids were affected, but the left the more severely, almost all the cilia having been destroyed. Local treatment only was adopted, and the patient is progressing very satisfactorily.

CASES OF NERVE DEAFNESS.

DEMONSTRATED BY DUNDAS GRANT, M.D., F.R.C.S.

CASE I.—*Hysterical Nerve Deafness, with Spontaneous Recovery.*

Miss A., aged 18, came under my care on May 27th, 1895, complaining of deafness of both ears, stuffiness in the nose, and pain in the throat. The deafness was of three years' duration, and it had come on gradually, but had got very much worse immediately after the extraction of eight teeth three months before coming to me. For this operation she was anæsthetised with gas and ether. On examination the hearing was practically the same in both ears. She could only hear very loud conversation, and apparently only when her hearing power was supplemented by lip-reading. The watch was heard at 6 inches, Galton's whistle was heard up to the mark 3·8, the bone conduction on both mastoids was diminished, and Rinne's test gave a "positive" result in both ears. There was pain over the mastoids, no discharge was present, and there was no definite history of any previous discharge. At that time she described certain indefinite attacks of giddiness, of which she has now lost all recollection. On testing her hearing for various tuning-forks by air conduction, she was found to have completely lost the hearing for " C_2 " and for " C_1 ," while for the other forks, extending from " C " up to " C^5 ," the amount of hearing power varied from 3 or 4 per cent. up to 15 per cent.

A diagnosis was then made of nerve deafness of indeterminate origin, but probably "auto-suggestive." Ammoniated tincture of valerian was ordered, blisters were applied to the mastoid process, and galvanism by means of the continuous current to the strength of 10 m.a., with the negative rheophores applied to the tragi, was employed for 10 minutes at a time. The treatment was varied in the usual way, and the changes were freely rung on strychnia, bromide of potassium, and ultimately the liquid extract of ergot. No improvement of any moment took place, with the natural result that the patient withdrew from further treatment. At present she has come back to say that her hearing is perfectly good, it having returned in January, 1897, after a "complication" of ailments, which confined her to bed for a fortnight.

While lying in bed her hearing rapidly improved, until in six months it became perfectly normal, and she can now hear a whisper with the right ear at the distance of about 14 feet, and with the left at 13 feet. She has about normal hearing power for the watch-tick.

This spontaneous recovery seems to confirm the original diagnosis.

In this case the tuning-fork test for middle tones "C¹" answered to this type of nerve deafness, and was sufficient to exclude middle-ear disease. The tests for air conduction throughout the whole range of audition indicated that the maximum of loss was for deep tones. In typical disease of the labyrinth the opposite would be the case, and we should expect to find the loss greatest in the uppermost part of the range, the lower part being relatively less defective. The combination then agrees with that described by Gradenigo as typical, on the other hand, of disease of the nervous centres, and, in fact, exactly with what he describes as occurring in hysterical nerve deafness, as set forth in his article in Schwartz's text-book. In his more recent publication on auditory disturbances occurring in hysteria he describes the loss of hearing as being fairly uniform throughout the whole range, but more marked in the lower range, on account of the physical nature of tuning-fork vibrations, rather than from peculiarities in the distribution of the disease in the hearing structures. The confirmation of the diagnosis originally made has in this case been very late in coming, but it seems to be unquestionable.

CASE II.—*Sudden Nerve Deafness of Doubtful Nature, but probably Hysterical.*

M. D., nurse, aged 40, was referred to me on account of deafness in her right ear. For many years she had suffered from suppurative inflammation of the left ear, but recently, when she awoke in the morning, she found herself almost completely deaf in the right ear. Her menses had been present with abnormal profuseness, and at the same time she had a severe attack of what she supposed to be diarrhœa, and which was accompanied by a very considerable discharge of blood from the bowels. Two days after the occurrence of the deafness she became affected with severe vertigo and a feeling of sickness, but the vertigo was rather of the nature of a confusion, than actually a sensation as if things were rotating round her. On testing

her hearing it was found that the defect was a nerve deafness, but that the hearing for the highest-pitched tones was comparatively well preserved.

On examination it was found that the whispered voice could not be heard at a greater distance than 3 inches; the watch was heard at 2 inches. The tuning fork on the mastoid was rather diminished, though not in proportion to the degree of apparent deafness, and Rinne's test was positive, thereby excluding any material amount of obstructive lesion in the right ear, and supporting a diagnosis of nerve deafness. The range for high-pitched tones was tested by means of Galton's whistle, and was found to be good up to 0·9, which for the instrument employed was practically normal. Her hearing was tested with a series of tuning forks with air conduction, and the deafness is most marked for the middle tones, the highest and lowest being much less defective.

A nerve deafness, which does not especially affect the hearing for the high-pitched tones, is probably unconnected with the cochlea, and is more likely to be due to affection of the auditory centres, generally of functional or hysterical nature. In the present instance there was found comparative hemianæsthesia on the right side of the face and body, diminution of the pharyngeal reflex, and highly exaggerated knee-jerks. A sudden nerve deafness is generally due to an effusion into the labyrinth, a rapidly-developed congestion or anæmia of the part, or a hysterical disturbance. In the present instance the last named seemed the most probable, and the patient was encouraged to expect improvement, while the ammoniated tincture of valerian was ordered to be taken three times a day. Within a few days a remarkable improvement took place, and at the time of the demonstration her hearing had very nearly returned to the normal. The correctness of the diagnosis seems practically established by the recovery.

REVIEWS AND NOTICES OF BOOKS.

SURGICAL ANATOMY. *A Treatise on Human Anatomy in its Application to the Practice of Medicine.* By John B. Deaver, M.D. (Published by Rebman Co.)

We have received Vol. I, and it is to be completed in three. It is an atlas of plates and diagrams, with abundant letterpress description, and devotes itself with great success to the task suggested by its title. It supplies to the practitioner exactly the kind of anatomical information which he is likely to require in the emergencies of practice. The plates are admirable.

HAND ATLAS DER HAUTKRAUKHEITEN. By Professor M. Kaposi.

Hebra's renowned successor has undertaken in this work the re-issue of his father-in-law's atlas in smaller form and with very large additions. Two volumes in large quarto are out, and two others will probably complete the publication. It will be one of the utmost value to dermatologists. The plates, although much reduced from life size, are still large enough to exhibit the features of the disease exceedingly well. All are in colour. The work as an atlas is brought well up to date, almost all, even the rarest, forms of disease being represented. We may be permitted to regret the absence of letterpress, for not only is there no description of the disease but no facts whatever as to the individual patients are given. The malady is simply named. This is a great drawback for the specialist, though perhaps of less consequence to others. No fewer than 240 excellent portraits are given in these two volumes, and when the whole 500 are produced the Atlas will be by far the most nearly complete of any ever published. The nomenclature is in Latin, and the work will no doubt have a large international sale.

BACTERIA. *Especially as they are Related to the Economy of Nature to Industrial Processes and to the General Health.* By Dr. George Newman.

Dr. Newman's work supplies the best popular handbook extant on this topic. It is concise and clear, well illustrated, and not too long. Its author has, we believe, had long practical experience as a very successful teacher in Professor Crookshank's laboratory. It is one of the Progressive Science Series (Mr. Murray), and as such is published at a very moderate cost.

RAYNAUD'S DISEASE. By Dr. K. Munro, Physician to the Glasgow Royal Infirmary.

Under this title Dr. Munro has collected from all sources a great deal of valuable clinical information which he discusses with much judgment. It is possibly a trifle too systematic and too statistical for its subject-matter, but it is one which all clinical physicians will nevertheless welcome. Its author gives us as frontispiece a facsimile reprint of the title page of Raynaud's original work. (The work itself is one of the New Sydenham Society's Library, having been translated by it in 1887.) We rather regret that Dr. Munro persists in the use of the expression "Raynaud's disease," having thought that it had been shown that there is no single condition to which that name is applicable, and that it is far

better to speak of "Raynaud's phenomena," and to admit that they may form part of several different maladies. That, however, is a long story, and Dr. Munro deserves, meanwhile, our very best thanks for his book.

ATLAS DER SYPHILIS UND SYPHILISÄHNLICHEN HAUTKRAUKHEITEN. By Dr. Martin Chotzen, Breslau.

In a quarto volume of 158 pages, with 71 plates, Dr. Chotzen, who is, as his title page informs us, a specialist in diseases of the skin, has done his best to aid the student and general practitioner in the differential diagnosis of syphilitic eruptions from those which look like them but are not so. We must say for him that so far as pictorial illustrations can do this he has succeeded. Many of his plates are delicately finished, and display the characters of the disease very perfectly. Of the non-syphilitic diseases of the skin only those are given which are likely to be mistaken for syphilides. There is much in this often very difficult diagnosis which it is impossible to illustrate in a plate. That which is perplexing on the living skin does not become less so by being displayed in colours on paper. It is like expecting to see into a fog by the aid of spectacles. We repeat, however, what can be done our author has done. His letterpress is full and clear, and his plates are excellent. If they do not teach the practitioner everything he wants to know on the subject, they will at any rate teach him very much.

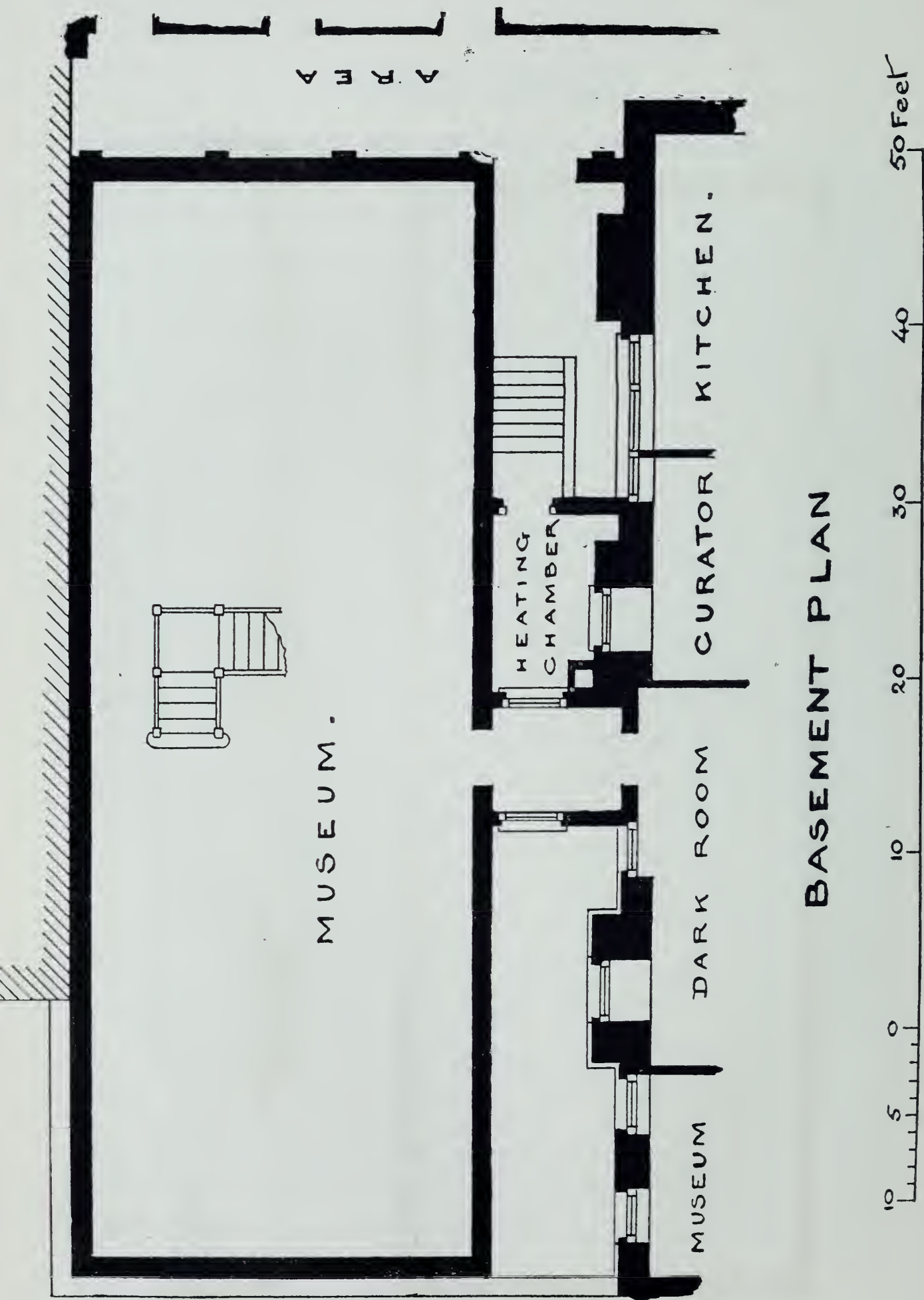
OUR CONSULTATIONS.

THE arrangements for the afternoon consultations which have been in force during the past six months must be considered to have been to some extent tentative. The experience which has been gained will, it is hoped, help us to yet better ones in the future. During the coming year at least four days a week, between the hours of four and half-past five, will be devoted to these consultations. Without attempting too much of detailed classification, certain classes of disease will be taken on certain days, and from time to time announcement will be made as to what those will be, and what consultants will attend. It is much desired by the Council that all subscribers will take their due share in promoting the success of these consultations. They are regarded as quite distinct from the more formal clinical lectures, for which arrangements will be made at other hours. At the consultations, questions and suggestions from those attending, so far from being considered as interruptions, will be welcomed. It is, however, in reference to the supply of patients that the active co-operation of all is so desirable. Until the reputation of the College as a Consultation Hospital is established it is not to be expected that any large attendance of

spontaneous applicants for advice will be secured, and it may possibly at all times be a little difficult to obtain the attendance of those most wished for. There will always be the drawback that many may not like to be brought for consultation before so many observers. This natural repugnance may, however, be overcome by judicious persuasion on the part of those in whom the patient confides. It will, however, we may remark in passing, always be sufficient to prevent the abuse of the opportunities offered for gratuitous consultation. What we desire of our members is that they should assist the College by sending instructive cases. We cannot venture to rely wholly on the attendance of patients who themselves desire advice, or for whom their medical attendants wish it. These will, we believe, afford the larger number, and have indeed done so in the past, but there are yet others concerning whom no great personal benefit may be possible, who may yet supply occasion for a consultation likely to prove of great benefit to the class. These we like to have as well as the *bonâ fide* consultation cases. As regards the latter, we may state that letters of recommendation are now at the disposal of all subscribers, and that patients certified as suitable will always be gladly received. Medical men sending patients, and not able themselves to accompany them, may always receive a report if their wish to that effect be duly conveyed to the Medical Superintendent. For cases in which it can aid the diagnosis—fractures and the like—the Röntgen Ray apparatus is always ready, and, in connection with the Pathological Laboratory, examinations of morbid products, tumours, and the like, can be conducted. It is to be clearly understood that no advantage is to be taken of these arrangements to obtain help in the cases of patients who ought to pay fees, and that in all the patient is willing to be produced at a public consultation. In ordinary cases patients desiring consultation come before the consultant for the day, but in those of exceptional interest and difficulty arrangements can be made for Special Consultations with more than one of those whose services have been placed at the disposal of the College. For these consultations a week's notice should be given to the Medical Superintendent, and particulars as full as practicable should be supplied. It is obvious that pre-arranged consultations of this kind will be of the utmost interest to those who listen to them. In some instances it may even be practicable in connection with the Journal to supply to the class a printed statement of the patient's case.

THE NEW MUSEUM.

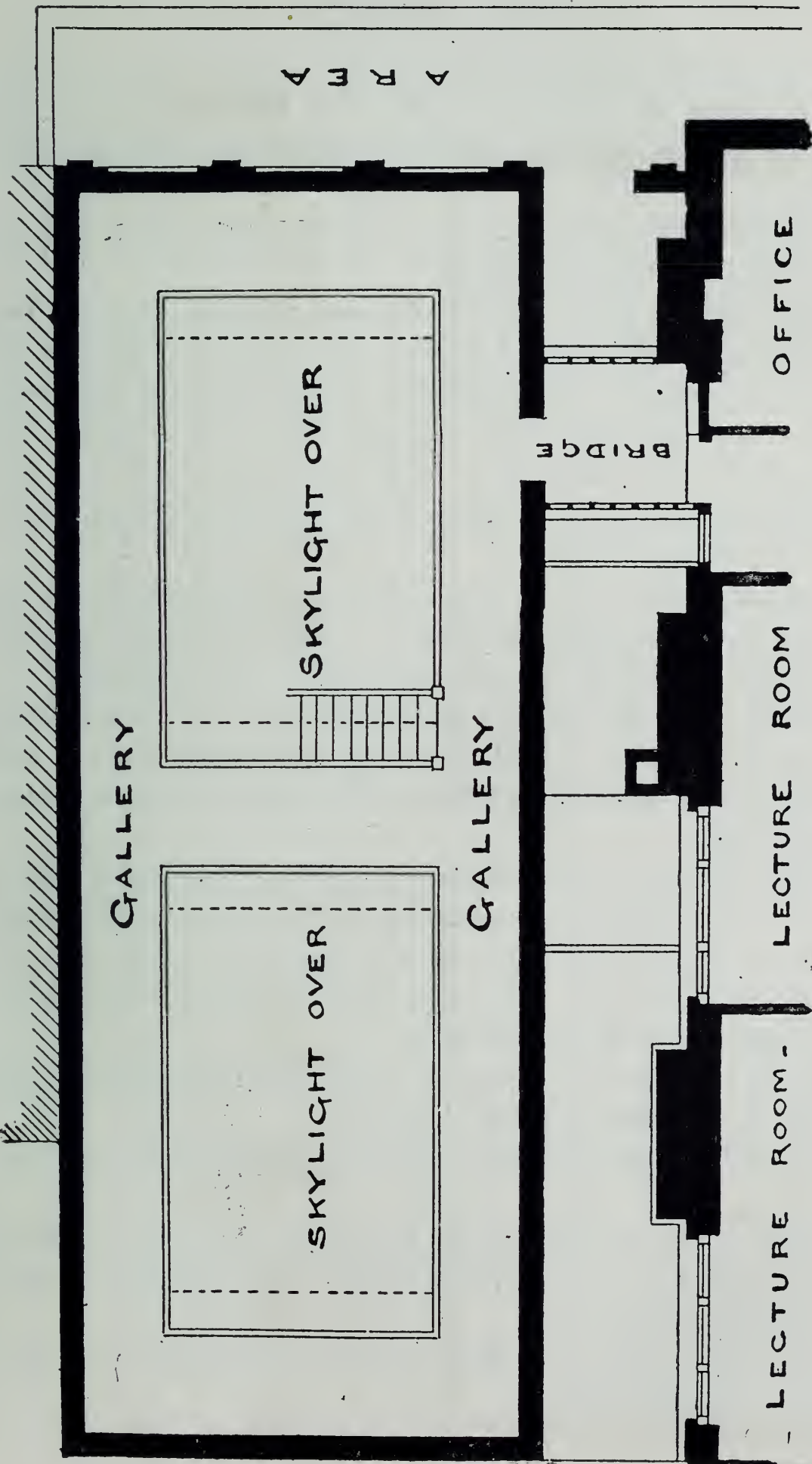
ON the following pages are given the plans for our new Museum, together with statements from the architect, Mr. Marshall, as to its dimensions, &c. It will be a large building of one room, with a broad gallery running round it, and a staircase and landing platform in its centre. The contract with the builders names the end of March for its completion. It is proposed to combine in the same room both library, reading room, and museum, but the arrangements are not final. The library will probably consist of open book-shelves, and will be one chiefly for practical reference. In it, as well as in the Museum, the leading idea will be to collect what can be made useful in the investigation and illustration of disease. A large number of drawings and books and a few models, &c., are already at the disposal of the Council, and will be put in place as soon as the building is ready. Additional donations will, however, be welcomed. It is proposed to devote much space to the adequate display of instruments and appliances, but to exclude for the most part, if not absolutely, the drugs and food preparations which take up so much room in most of our temporary exhibitions. Pathology, as illustrated by spirit preparations, will not be wholly kept out, but will not be cultivated, as it is already adequately provided for elsewhere. Only such preparations will be admitted as are likely to be immediately useful in clinical teaching. On the other hand, no pains will be spared to make the collection complete and easily accessible as regards the pictorial illustration of symptoms and morbid conditions. It will be emphatically a Clinical Museum as distinct from a purely pathological one. As regards anatomy and physiology, it is proposed that it shall include only such objects as have a direct bearing on clinical research. As far as possible all objects will be so placed that they may without trouble be easily transferred to the lecture room. The close juxtaposition of the Museum with the lecture room will greatly facilitate this. There will be two entrances to the Museum: one from the basement and one on a level with the hall, through the lobby by the Superintendent's room.



BASEMENT PLAN

C H E N I E S S T R E E T .

A R E A



GROUND FLOOR PLAN.

BY THE ARCHITECT.

THE Museum now being built for the College will be a room 61 feet 6 inches by 21 feet 6 inches, and 19 feet high, and will occupy the greater part of the area to the west of the College buildings.

The floor is on the same level as the old basement floor, from which it will be reached by a short passage.

There will be, at a level of 11 feet 6 inches above the floor, a gallery 4 feet wide at the sides and 5 feet at the ends of the building, the side galleries being also connected by a central bridge; a staircase by the side of this will lead to the basement floor. These galleries will have access to the College by a bridge, connecting with the main entrance-hall by the passage at the side of the Medical Superintendent's room.

The building will be lit by two large double-glazed skylights, and warmed by hot-water pipes, the inlets for fresh air being arranged so that in winter the air will be warmed by contact with these pipes.

An electric fan in the ceiling will provide for the extract of foul air.

The floor will be pitch-pine block flooring, and the whole of the walls will be lined with boarding to facilitate the attachment of the various fittings required.

The building has been kept at a level which it is considered will not interfere with the light of the existing west windows on the ground floor. The floor space, including galleries, amounts to 2,000 feet; the wall space to 3,000 feet. The area of the skylights is 490 feet, so that the building will be thoroughly lit.

It is expected that the absence of windows, the block flooring, and the position of the room will make it quiet.

All air inlets being screened, it should be comparatively free from dirt.

The plans, which accompany this Report, are prepared by Messrs. Marshall and Vickers, and are a modification of a previous design made by Mr. Herbert Hutchinson.

The builders are Messrs. Prestige and Co., who are under contract to complete by the end of March.

COLLEGE NOTES.

DURING 1899 only two numbers of the Journal were issued, and with a considerable interval. It has, however, in now commencing a regular monthly publication, been thought most convenient to let the two numbers rank as Vol. I, and to commence the year with Vol. II, of which the present will constitute the first part. The Journal will be sent post free to all Members and Subscribers, and will be procurable by others by the prepayment of 12s. 6d. for the year's issue. A specimen copy will be supplied to any member of the profession on receipt of three penny stamps for postage.

* * *

By a special resolution of the Council, the list of original Subscribers to the College was closed on December 31st. The names and addresses of those who are included in this list will be found at pp. 3 to 15. All these will enjoy the privileges of original Subscribers so long as their subscriptions are punctually renewed. The terms of subscription to those joining in the future will be two guineas per annum.

* * *

THE privileges accorded to Subscribers (whether original or otherwise) are:—The use of the Library and Museum; attendance at all afternoon Consultations, and at all Lectures or Committees which may be declared “open”; and to receive, post free, the College Journal.

* * *

THERE is a difference between a “Subscriber” and a “Member,” which needs explanation. In each instance the name of a candidate for election must be approved by the Council. The annual payment is the same, and the privileges, as mentioned above, are the same. A Subscriber, however, incurs no responsibility, and takes no part in the management of the College; he cannot attend the Annual Meeting, or vote at elections. A Subscriber wishing to rank as a Member must make special application, in writing, to the Dean, and, if approved, his name will be placed in that list, and he will become eligible for all offices, and entitled to vote at all meetings of Members. His financial responsibility as a Member of the Incorporated College is limited to 10s.

IN the Polyclinic formalities of election are reduced to a minimum. For obvious reasons, the Council reserves to itself the right of approval in regard to all candidates, whose names must therefore be submitted before their election is confirmed. Subject to that approval, however, which will never be withheld except for the strongest of reasons, our doors are open to all who, in accordance with the Articles of Association, are eligible for election.

* * *

EVERY Member of the College will learn with regret that Dr. Fletcher Little, our genial Honorary Secretary, has felt himself compelled to resign his post by the pressure of other engagements. No man has worked harder for the advancement of post-graduate tuition than Dr. Little, and while we regret losing the advantage of his secretarial experience, we are consoled by the knowledge that in a position of higher dignity as Vice-President, to which he has now been elected, he will still give the College the advantage of his energetic co-operation.

* * *

THE greater part of the duties of Secretary will in the future be associated with those of the Resident Superintendent, and no honorary officer will be appointed as Dr. Little's successor.

* * *

THE Council of the College deems itself very fortunate in having persuaded Dr. Guthrie Rankin to take upon himself a general directorship of the affairs of the Institution, under the title of Dean. It is well assured that, amongst those who have taken interest in the formation of the College, there is no one better qualified than Dr. Rankin to guide its future course with skill, judgment, and success. The duties connected with the post are neither few nor light, and Dr. Rankin, in undertaking them, merits the best thanks and hearty co-operation of all concerned.

* * *

As announced in our last, the resignation of Dr. Hawthorn left the post of Medical Superintendent vacant. Captain Hayward Pinch, who has been elected to it, comes to us with the highest qualifications. He is a Fellow of the Royal College of Surgeons of England, and a Captain in Her Majesty's Indian Medical Service. He has done a very considerable amount of laboratory work both at home and abroad, and has had a varied and useful experience in the executive management and tuition of medical classes. Captain Pinch has been chosen from a large list of candidates, and the Council looks forward with confidence to his justifying the flattering eulogia of his numerous testimonials.

ARRANGEMENTS are being made for the delivery of Clinical Lectures in the College by men who are authorities on the subjects with which they will deal. It is proposed to hold these lectures at first once a fortnight, on alternate Fridays, at 5 P.M., but if sufficient support is accorded them by the members of the College, they will be extended to one every week. The first lecture will be given by Sir Wm. Broadbent, our President, on January 17th, on the Subject of "Insomnia." He will be followed by Professor McCall Anderson, of Glasgow, Dr. Patrick Manson, Dr. Saundby, of Birmingham, and others.

NOTES ON THE SURGERY OF THE WAR.

BY THE EDITOR.

THE often quoted Homeric lines—

A. wise physician skilled our wounds to heal
Is more than armies to the public weal,

are receiving very cogent illustration in the present war. Never before in the history of the world were wounded soldiers more rapidly restored to the combatant ranks. Lord Lister, although he has stayed at home, has certainly won more laurels than anyone else has as yet earned; nor is it the less a matter of congratulation that he has assisted our opponents as well as ourselves. The term "wounded" will soon cease to have the fearful significance which it once had, and those coming under it will hardly be counted as "losses" when it is recognised that two-thirds may probably be back in the ranks within a fortnight.

Now that it is found that to be shot through the lungs involves but little risk, and that bullet wounds of the limbs count for almost nothing, whilst those of the abdomen, the liver, and even the head, are far from being necessarily fatal, it seems possible that some return to defensive armour may be practicable. The region of the heart is the part which remains mortally vulnerable, and it may, perhaps, be found practicable to contrive a breast-plate which may be worn without encumbrance and yet conduce much to the wearer's security.

In connection with the suggestion just made it would be of much interest if those who have opportunities would collect statistics as to the precise nature of the injuries of those who are killed on the modern battlefield.

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

WINTER SESSION, 1900.

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis	{	Seymour Taylor, M.D., M.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S.
Clinical Examination of the Nervous System	{	James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.
Practical Ophthalmology : the use of the Ophthalmoscope and Refraction	{	E. Treacher Collins, F.R.C.S. W. Holmes Spicer, M.B., F.R.C.S. L. Vernon Cargill, F.R.C.S.
Practical Otology	{	Arthur H. Cheatle, F.R.C.S. Richd. Lake, F.R.C.S. J. Dundas Grant, M.D., F.R.C.S.
Practical Rhinology and Laryngology	{	St. Clair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P.
The Application of the Röntgen Rays		F. Harrison Low, M.B.

COURSES OF LECTURES.

General Ophthalmology... ..	R. Marcus Gunn, M.B., F.R.C.S.
Insanity: its Medical and Legal Treatment	G. H. Savage, M.D., F.R.C.P.
Lectures and Demonstrations on Diseases of the Skin	Phineas S. Abraham, M.D., F.R.C.S.
Comparative Pathology	Woods Hutchinson, A.M., M.D.

CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology	Professor Crookshank, M.B.
Mental Diseases... ..	Maurice Craig, M.D., M.R.C.P.
Hygiene and Public Health	A. Wynter Blyth, M.R.C.S., F.C.S.

JANUARY TERM, 1900.

Commences Monday, January 15th ; ends Friday, February 23rd.

CLINICAL CONSULTATIONS AT 4 P.M.

Mondays (Skin) ; Tuesdays (Medical) ; Wednesdays (Various) ;
Thursdays (Surgical) ; Fridays (Eye, Ear, Throat, and Nose).

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis. Tuesdays and Thursdays, at 6 P.M. Commences Tuesday, January 16th. Fee, £2 2s. Dr. Seymour Taylor and Mr. James Cantlie.

Clinical Examination of the Nervous System. Fridays, 2 to 3 P.M. Commences Friday, January 19th. Fee, £1 1s. Dr. Harry Campbell.

Practical Application of Röntgen Rays. Thursdays, 3 P.M. Commences Thursday, January 18th. Fee, £2 2s. Dr. Harrison Low.

Practical Ophthalmology : the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M. Commences Friday, January 19th. Fee, £2 2s. Mr. Vernon Cargill.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commences Wednesday, January 17th. Fee, £2 2s. Dr. St. Clair Thomson.

Practical Otology. Mondays, 5 to 7 P.M. Commences Monday, January 15th. Fee, £2 2s. Dr. Dundas Grant.

LECTURES.

(Conditional upon a minimum number of entries being received.)

Diseases of the Eye. Mr. Marcus Gunn.

Diseases of the Skin. Dr. Phineas Abraham.

Comparative Pathology. Dr. Woods Hutchinson.

Insanity : its Medical and Legal Treatment. Dr. Savage.

Fee for any one course of Six Lectures, £1 1s.

LABORATORY AND CLINICAL CLASSES.

Practical Bacteriology. Daily, 10 A.M. to 1 P.M., and 2 to 5 P.M. Fee, £5 5s. Professor Crookshank.

Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee, £2 2s. Professor Crookshank.

Hygiene and Public Health. Fee, £2 2s. Mr. Wynter Blyth.

Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.

SYLLABUS OF TEACHING.*

Clinical Lectures will be given on alternate Wednesdays at 5 p.m., commencing January 17th.

CLINICAL CONSULTATIONS.

These will take place in the afternoon, between the hours of 4 and 6. Particulars will be announced at the Polyclinic, in the Journal, and in the weekly Medical Press. In connection with these Consultations, Clinical Assistants will be appointed. For the present, Consultations will be held every Monday, Tuesday, Wednesday, Thursday, and Friday.

PRACTICAL CLASSES.

Entries for the following Practical Classes may now be made. *Each course will extend over six weeks*, and will be conducted so as to afford practical instruction to each member of the class. Patients illustrating the various diseased conditions will be submitted for examination. The number of students permitted in each class will be limited, but, if required, supplementary classes will be provided :—

MEDICAL AND SURGICAL ANATOMY AND PHYSICAL DIAGNOSIS.

Tuesdays and Thursdays, 6 to 7 P.M., commencing January 16th.

Fee :—Two guineas.

This course will be illustrated on the living subject, and by specimens, diagrams, and models. It will include—

1. Practical instruction in the normal positions of the several organs and their various parts, and the relationship of surface anatomy to the subjacent viscera.
2. The principles and methods of case-taking.
3. The application of inspection, palpation, mensuration, percussion, and auscultation in the clinical study of the thoracic and abdominal viscera.

* All communications regarding the classes should be addressed to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

4. The use of medical instruments and apparatus, with demonstrations of methods and results. In this section will be studied the Cardiograph, Sphygmograph, Pneumograph, and records obtained by their aid; the Clinical Thermometer and Temperature Charts; the Hypodermic Syringe and its use; the Stomach Pump and Stomach Syphon; Southey's Tubes and various Aspirators; Inhalers and Intra-Laryngeal Medication; Enemata, their preparation and use; Venesection, Transfusion, &c., &c.

5. BONES.—Mechanism; structure as bearing on fractures.

6. JOINTS.—Anatomy; dislocations and principles of reduction.

7. MUSCLES.—Grouping of muscles according to action and nervous supply; tendons, their sheaths and division points; club foot.

8. ARTERIES.—Anatomy of main arteries; points at which pressure is most readily applied; sites for ligature; collateral circulation; tourniquets.

9. VEINS.—Anatomy; venesection; varicose veins.

10. LYMPHATIC SYSTEM.—Grouping of glands; distribution of lymphatics.

11. NERVOUS SYSTEM.—Brain, and the localisation of cranial lesions; the convolutions, centres, origins of cranial nerves, vascular supply, relations to surface of skull; trephining. Cranial nerves, anatomy, diagnosis of lesions affecting. Spinal nerves, their area of supply; localisation of spinal lesions; laminectomy; operations for spina bifida.

12. REGIONS.—Cranium; orbital, nasal, oral, and aural regions and cavities. Limbs, the surgical anatomy of. Fractures, their anatomy, and principles of treatment. The surgical anatomy of hernia and the genito-urinary organs.

Bandaging. Application of splints. Surgical instruments.

THE METHODS OF INVESTIGATING CASES OF DISEASE OF THE NERVOUS SYSTEM.

Fridays, 2 to 3 P.M., commencing January 19th.

Fee:—One guinea.

The anatomy and physiology of the nervous system.

Brain and spinal cord topography.

Functions of the brain and spinal cord.

Family history in nervous disease.

Personal history and habits in nervous disease.

Condition of the patient at the time of examination.

General Appearances.—Unsteadiness, tremor, deformities, pallor nervousness, &c.

Gait—Spastic, ataxic, hemiplegic, functional disturbances.

Spontaneous movements.—Choreiform; athetoid; tremor.

Speech defects—Articulatory; aphasic.

Motor Symptoms.—Paraplegia; monoplegia; hemiplegia; cranial nerve paralysees; isolated paralysis of spinal segments; isolated paralysis of spinal nerves; general neuritis; electrical testing.

Sensory Symptoms.—Spontaneous sensations; impaired sensibility, common, for pain, for heat and cold; perverted sensibility, allocheiria, &c.

Special Senses.—Smell; taste; vision; ophthalmoscopic appearances; hearing.

Trophic symptoms.

Cases illustrating different types of nervous disease.

THE USE OF THE RÖNTGEN RAYS IN MEDICINE AND SURGERY.

Thursdays, at 3 P.M., commencing January 18th.

This subject will be taught in the laboratory, which has recently been equipped with the most modern apparatus. Instruction will be given in short courses of practical work under the supervision of Dr. Harrison Low, and each member of the class will have the opportunity of practising the necessary methods and processes. It is proposed that the laboratory shall be open for teaching on Thursdays at 3 P.M., but in respect to days and hours, an endeavour will be made to meet the convenience of practitioners wishing to study this subject. Fee for four practical lessons:—Two guineas.

PRACTICAL OPHTHALMOLOGY: THE USE OF THE OPHTHALMOSCOPE AND REFRACTION.

Fridays, 5 to 7 P.M., commencing January 19th.

Fee:—Two guineas.

- I. Optical principles and subjective testing.
- II. The ophthalmoscope, and how to use it.

- III. Retinoscopy.
- IV. Abnormalities of refraction and the prescribing of glasses.
- V. Ocular movements : their anomalies and derangements.
- VI. The field of vision.

PRACTICAL RHINOLOGY AND LARYNGOLOGY.

Wednesdays, 5 to 7 P.M., commencing January 17th.

Fee :—Two guineas.

Members of the class are requested to provide their own laryngoscopes and the ordinary instruments required for clinical examination. (A list of these will be provided by the teacher.) The class is held in the dark room, and for each member there is a separate table and laryngoscope lamp.

The practical examination of the upper air passages will be demonstrated on patients, and the course will be illustrated by instruments, models, drawings, diagrams, and specimens.

Jan. 17.—Methods of illumination ; position ; necessary instruments ; the external nose.

„ 24.—The examination of the nasal fossæ ; specula ; probes ; cocaine ; the medication of the nasal cavity, composition of nasal lotions, &c. ; affections of the septum.

„ 31.—The accessory sinuses of the nose, their situations, openings, relations, and the methods of their exploration ; transillumination ; the physiology of smell and of nasal respiration.

Feb. 7.—The naso-pharynx and pharynx ; the tonsils.

„ 14.—The larynx.

„ 21.—The trachea and œsophagus ; tracheotomy ; intubation ; dysphagia.

PRACTICAL OTOLOGY.

Mondays, 5 to 7 P.M., commencing January 15th.

Fee :—Two guineas.

- I. Inspection of auricle, meatus and membrane, specula, &c. ; air and bone conduction ; tests for hearing ; rules for using the tuning-fork, Rinne's test, &c. (Cases.)

- II. Diagnosis of obstructive and nerve deafness in general ; cerumen ; indrawn membrane, dry perforations, cicatrices, &c. ; Siegel's speculum, " artificial drum," &c. (Cases.) Syringing.
- III. Varieties of obstructive deafness ; examination of the Eustachian tubes, rhinoscopy, inflation, auscultation, Politzer's bag, Eustachian catheter, &c. (Cases.)
- IV. Discharges from the ear, cleansing, instillation of drops, cauterisation, &c. ; mastoid disease, &c., polypi, granulations, " attic disease." (Cases.)
- V. Varieties of nerve-deafness, labyrinthine, central, functional, &c. ; use of Galton's whistle, &c. ; investigation of auditory and neighbouring nerves, &c. (Cases.)
- VI. Varieties of tinnitus aurium ; compression of vertebral arteries ; application of galvanism. (Miscellaneous cases.)

On each occasion the members of the class will receive a typed *résumé* of the matter dealt with. The most of the time will be occupied in the actual examination of cases.

COURSES OF LECTURES.

General Ophthalmology.

BY R. MARCUS GUNN, F.R.C.S.,

Surgeon to the Royal Ophthalmic Hospital, Moorfields, &c.

Fridays, at 3 P.M., commencing January 19th.

Fee :—One guinea.

LECTURE 1.—On the external examination of the eye.

LECTURE 2.—Visual tests.

LECTURE 3.—Syphilitic affections of the eye.

LECTURE 4.—Gouty, rheumatic, and tubercular affections of the eye.

LECTURE 5.—Glaucoma.

LECTURE 6.—Ocular therapeutics.

Insanity : Its Medical and Legal Treatment.

BY GEO. H. SAVAGE, M.D., F.R.C.P.,

Lecturer on Mental Diseases, Guy's Hospital Medical School.

Wednesdays, at 5 P.M., commencing January 17th.

Fee :—One guinea.

OUTLINE OF COURSE.

Medical, social, and legal relationships of Insanity.

Forms of Insanity and their relations to allied normal conditions.

Origin of Insanity, as a disorder, as a disease of the brain, as a symptom of bodily disease.

Development of symptoms, course and termination of the disorder.

Social and legal responsibilities involved in treatment.

Diseases of the Skin.

A course of six demonstrations will be given by P. S. Abraham, M.A., M.D., F.R.C.S. (Surgeon to the Hospital for Diseases of the Skin), on Wednesdays at 5 p.m., commencing January 17th.

A number of cases will be shown at each demonstration, and especial attention will be given to their diagnosis and treatment.

Comparative Pathology.

BY WOODS HUTCHINSON, A.M., M.D.,

Professor of Comparative Pathology in the University of Buffalo, U.S.A.

Thursdays, at 3 o'clock, commencing January 18th.

Fee :—One guinea.

I. Diseases of the Alimentary Canal, their Similarities and Differences in the various Classes of Animals. Diseases of the Stomach in Carnivora. Diseases of the Stomach in Herbivora. Diseases of the Stomach in Mixed Feeders.

II. Diseases of the Small Intestine. Diseases of the various Types of Cæcum.

III. Diseases of the Lungs and Chest Walls in various Classes: Pneumonias, Bronchitis, Influenza, Pleurisies.

IV. Deformities of the Chest in relation to Types of Respiration.

V. Diseases of the Heart and Blood : Valvular Lesions, Myopathies, Affections of the Vessel-Walls, Anæmias, Hæmoglobinuria of Horses.

VI. Diseases of the Kidneys, Skin, and Appendages : Nephritis and its Consequences, Affections of the Urine, Eczema, Acne, Psoriasis, Scabies.

VII. Tumours in Mammals, Birds, and Fishes. Analogous processes in Plants.

VIII. Diseases of Genito-Urinary Organs : Cystitis, Stone, Syphilis, Menstrual Disturbances.

IX. Gout in Animals and Birds.

X. Tubercle in Animals and Birds. Avian, Bovine, and Human Types of the Disease.

XI. Tubercle, Zoological Distribution. Susceptibility and Immunity of various Classes.

XII. Types of Tubercular Disease according to Host. Methods of preventing its spread.

CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology.

BACTERIOLOGICAL LABORATORIES, KING'S COLLEGE, STRAND, W.C.

Director.—Professor CROOKSHANK.

Demonstrator.—Dr. NEWMAN, D.P.H.

Assistant Demonstrator.—Dr. NASH, D.P.H.

(A) POST-GRADUATE CLASS.

Daily, 10 A.M. to 1 P.M., and 2 P.M. to 5 P.M., for 30 days, commencing Monday, January 15th.

Fee :—Five guineas.

The Secretary for the Colonies has intimated to the Council of King's College that, in selecting candidates for the Colonial Medical Services, preference will be given (other things being equal) to qualified medical men who have received such bacteriological or similar special training as King's College provides.

A Certificate is granted for this Course.

This course includes admission to the Laboratory for practical work daily for a month during term, and attendance upon a course of Demonstrations on the following subjects :—

SYLLABUS.

(a) MICROSCOPE—

Lenses—Spherical aberration—Chromatic aberration—Dry, water, and oil immersion objectives—The Stand—Ross model—Jackson model.

Illumination—Daylight and Artificial light—Abbé condenser—Microscopical accessories—Micro-photography.

(b) MICROSCOPICAL METHODS—

Examination of fresh specimens—Cover-glass preparations—Ehrlich's method—Ziehl-Neelsen method—Gram's method, &c.

Preparation of morbid specimens—Hardening—Embedding—Celloidin—Microtomes and section cutting.

(c) CULTIVATION METHODS—

Principles of sterilization—Bacteriological apparatus—Preparation of nutrient gelatine; nutrient agar-agar; glycerine agar-agar; blood serum; potato cultivations—Elsner medium.

Test-tube cultivations—Plate cultivations—Drop cultivations—Examination of air, soil, water, milk, and sewage effluents.

(d) BIOLOGY OF BACTERIA—

Chemical composition—Respiration and nutrition—Form—Classification—Circumstances affecting growth; products of growth—Chromogenic, zymogenic, septic, and pathogenic bacteria—Nitrification.

Pptomaines—Toxines and Antitoxines—Vaccines—Attenuation of virus—Protective inoculation—Immunity—Serum Therapeutics.

Disinfection—Antiseptics.

(e) INFECTIVE DISEASES—

Anthrax—Symptomatic anthrax—Malignant œdema.

Tuberculosis—Leprosy—Actinomycosis—Madura foot.

Glanders—Syphilis—Beriberi—Yaws—Verruga pernana.

Typhoid fever—Tropical typhoid—Dysentery.

Swine fever—Swine measles.

Cholera—Relapsing fever—Malaria—Dengue—Malta fever—Surra.

Pneumonia—Rabbit septicæmia—Chicken cholera.

Mouse septicæmia—Suppuration and septic complication—Tropical abscess—Strangles.

Tetanus—Rabies.

Scarlet fever—Diphtheria—Small-pox.

Cow-pox—Horse-pox—Sheep-pox.

Foot and mouth disease—Pleuro-pneumonia—Cattle-plague.
 Influenza—Plague—Yellow fever.
 Oriental sore—Human and Bovine ringworm.

The courses of instruction are similar to those given at the Pasteur Institute (Paris), and the Hygienic Institute (Berlin).

Text-Book of the Laboratory — “Crookshank’s Bacteriology and Infective Diseases.”

(B) CLINICAL CLASS.

Wednesdays, 2 to 3.30 P.M.

Six clinical demonstrations, with practical work, will be given on Wednesdays, commencing January 17th.

Fee:—Two guineas.

- (1) Micrococci—Bacillus of Anthrax.
- (2) Tubercle and Leprosy bacilli.
- (3) Actinomyces fungus.
- (4) Plague and Influenza bacilli.
- (5) Diphtheria and Tetanus bacilli.
- (6) Cholera bacillus—Malarial parasites.

Demonstrations will be given on each of the above subjects, and an opportunity given to every member of the class to examine sputum, &c., and to make a series of permanent preparations of the bacteria referred to above. Each student is provided with a microscope and all materials.

Mental Diseases.

BETHLEM ROYAL HOSPITAL FOR LUNATICS.

Lecturer.—MAURICE CRAIG, M.D., M.R.C.P.

Tuesdays, 2 P.M., commencing January 16th.

Fee:—One guinea.

- Jan. 16.—Mania—Acute; Hysterical; Acute Delirious.
 „ 23.—Melancholia; Hypochondriasis; and Stupor.
 „ 30.—Delusional Insanity. Impulsive Insanities.
 Feb. 6.—Alcoholic Insanity. Lunacy Law.
 „ 13.—General Paralysis.
 „ 20.—Puerperal, Lactational, and Climacteric Insanities.
 Dementia.

Hygiene and Public Health.

BY WYNTER BLYTH, F.I.C., F.C.S.

LECTURE I.—AIR.—Composition of air. Impurities in air. Methods of estimation of carbon dioxide. Methods of estimation of carbon monoxide. Cubic space. General laws of ventilation. Ventilators. Methods of warming and ventilation.

LECTURE II.—CONSTRUCTION OF DWELLING-HOUSES.—Varieties of Dwelling-houses. Site, and means of obtaining sunlight and breeze. General construction. Methods of excluding ground air, vapour, dampness, and rain. Rooms, and internal arrangements of house. Surroundings of house.

LECTURE III.—HOUSE DRAINAGE.—Laying of Drains. Disconnection. Ventilation. Soil Pipes. Anti-Siphonage and Ventilation. Testing Drains and Soil Pipes.

LECTURE IV.—SANITARY APPLIANCES.—Water-Closets. Slop-Sinks. Urinals. Baths. Sinks. Treatment of Waste Pipes. Gullies. Defective Sanitary Arrangements.

LECTURE V.—REFUSE REMOVAL AND DISPOSAL.—Solid, liquid, and excretal refuse. Dry systems. Fixed and movable receptacles. Disposal of various kinds of solid refuse. Deposition. Utilisation. Destruction. Separate and combined systems of sewerage. Disposal of Sewage. Clarification. Precipitation. Filtration. Irrigation.

LECTURE VI.—SOURCES OF WATER.—Town and Country supplies. Pollution. Purification. Detection of Impurities. The Law as to Water Supply.

LECTURE VII.—INFECTIOUS DISEASES.—Incubation Periods. Duration of Infectivity. Compulsory Notification. Isolation. Removal to Hospital. Quarantine. School Closure. Fever and Small-pox Hospitals.

LECTURE VIII.—DISINFECTION AND DISINFECTANTS.—Deodorants. Preservatives. Antiseptics. Germicides. Chemical and Physical Germicides. Disinfection of interiors. Contained Air, Surfaces, and Contents of Infected Rooms. Treatment of various Infected Objects.

This class will be conducted at the Parkes Museum, Margaret Street, W. Date of first meeting, Wednesday, January 17th, at 4.30 p.m. Fee:—Two guineas.

CORRESPONDENCE AND ANSWERS.

To the Editor of "THE POLYCLINIC."

SIR,

I shall esteem it a favour if you will allow me, through your correspondence columns, to ask for some assistance in the work of arranging and cataloguing the books in our library, which I find a far greater task than I can possibly manage single-handed.

I had intentions of commencing the catalogue several months ago, but inasmuch as we were continually receiving additions to our stock of books, and as I had been promised a considerable number of modern volumes from the duplicate list of the library of the British Medical Association, I postponed action till these were received. These have now arrived, and form a handsome addition of over 200 volumes to the library, bringing up our total to nearly 4,000 volumes. What I ask for is the assistance of three or four of our members to form a small sub-committee, who will meet twice or three times a week and assist me in the work of the arrangement and cataloguing these volumes.

Within a few months it is intended to remove our library to the new building, now in course of erection, on the ground adjoining the Polyclinic; but inasmuch as the wall-space of the new Museum will be largely if not entirely required for the exhibition of pictures and diagrams of clinical and other interest our present arrangement of bookcases and shelves will not be interfered with or materially altered.

There is a further task for which I shall be glad of help, and I take this opportunity of asking for it, viz., the maintenance and keeping up to date of the extremely valuable collection of cuttings, extracts, pamphlets, and monographs which have been laboriously collected and arranged for some years past by, or under the direction of, Mr. Hutchinson, and generously placed by him at our disposal. They are arranged in some 200 volumes, in the form of manuscript or scrap albums under special headings, and if properly kept up will form a most valuable library in themselves for purposes of reference.

I shall be much obliged, therefore, if any members or subscribers who are interested in our library will kindly send in their names to me or to the Medical Superintendent, in order that we may, without further delay, commence this desirable and necessary work, so as to enable the increasing number of members, who frequent our reading room, to readily find for themselves any volume which they may wish to obtain.

Finally, I should like to appeal to all members to add to our library by gifts of books, especially modern editions of any text-books or works of reference; for although we have an excellent nucleus of a good library of books, ancient and modern, there is naturally a demand for the most recent editions of standard works. I need hardly say that any such books will be most gratefully accepted by the Library Committee, and none the less appreciated by the numerous members who frequent our most comfortable reading room.

Yours faithfully,

BOYD JOLL, *Hon. Librarian.*

December 19th, 1899.

DIARY FOR THE MONTH.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m.

JANUARY.

15	Monday	....	Consultation (Skin). Dr. Jas. Galloway.
16	Tuesday	....	Consultation (Medical). Dr. Seymour Taylor.
17	Wednesday	....	Clinical Lecture : "Insomnia." Sir Wm. Broadbent, Bart.
18	Thursday	....	Consultation (Surgery and Dermatology). Mr. Hutchinson.
19	Friday	....	Consultation (Ear and Throat). Dr. Dundas Grant.
20	Saturday	....
21	<i>Sunday.</i>		
22	Monday	....	Consultation (Skin). Dr. J. F. Payne.
23	Tuesday	....	Consultation (Medical). Sir Wm. Broadbent.
24	Wednesday	....	Consultation (Surgical). Mr. E. N. Roughton. 5.15, Sub-committee on Tuberculosis (open).
25	Thursday	....	Consultation (Surgical, &c.). Mr. Hutchinson.
26	Friday	....	Consultation (Nose and Throat). Dr. St. Clair Thomson.
27	Saturday	....
28	<i>Sunday.</i>		
29	Monday	....	Consultation (Skin). Dr. Jas. Galloway.
30	Tuesday	....	Consultation (Medical). Dr. Wm. M. Ord.
31	Wednesday	....	Clinical Lecture : "Mental Dissolution." Dr. Geo. H. Savage.

FEBRUARY.

1	Thursday	....	Consultation (Surgical, &c.). Mr. Hutchinson.
2	Friday	....	Consultation (Eye). Mr. Treacher Collins.
3	Saturday	....
4	<i>Sunday.</i>		
5	Monday	....	Consultation (Skin). Mr. Malcolm Morris.
6	Tuesday	....	Consultation (Medical). Dr. Theodore Williams.
7	Wednesday	....	Consultation (Medical). Dr. Guthrie Rankin. 5.15, Sub-committee on Climate (open).
8	Thursday	....	Consultation (Surgical). Mr. Hutchinson.
9	Friday	....	Clinical Lecture : "The Uses of Tuberculin in the Treatment and Diagnosis of Disease." Prof. McCall Anderson.
10	Saturday	....
11	<i>Sunday.</i>		
12	Monday	....	Consultation (Skin). Mr. Malcolm Morris.
13	Tuesday	....	Consultation (Medical). Dr. Theodore Williams.
14	Wednesday	....	Consultation (Medical). Dr. J. F. Payne. 5.15, Sub-committee on Leprosy (open).

DIARY FOR THE MONTH.

APPOINTMENTS AT OTHER INSTITUTIONS, SOCIETIES, &c.

JANUARY.

15	Monday	....
16	Tuesday	....	Pathological Society, 20, Hanover Square, 8.30.
17	Wednesday	....	Royal Microscopical Society, 8.30.
18	Thursday	....	Royal Society, 4.30.
19	Friday	....	Epidemiological Society, 8.30.
20	Saturday	....
21	<i>Sunday.</i>		
22	Monday	....	Medical Society, 8.30.
23	Tuesday	....	Medico-Chirurgical Society, 20, Hanover Square, 8.30.
24	Wednesday	....	Dermatological Society of Great Britain, 20, Hanover Square, 8.30.
25	Thursday	....	Royal Society, 4.30. Ophthalmological Society, 8.30.
26	Friday	....	Clinical Society of London, 20, Hanover Square, 8.30.
27	Saturday	....
28	<i>Sunday.</i>		
29	Monday	....
30	Tuesday	....
31	Wednesday	....

FEBRUARY

1	Thursday	....	Royal Society, 4.30.
2	Friday	....
3	Saturday	....
4	<i>Sunday.</i>		
5	Monday	....
6	Tuesday	....	Pathological Society (Laboratory Meeting), University College, 8.30.
7	Wednesday	....	Obstetrical Society, 20, Hanover Square, 8.
8	Thursday	....	Royal Society, 4.30.
9	Friday	....	Clinical Society, 20, Hanover Square, 8.30. Gynecological Society, 8.30.
10	Saturday	....
11	<i>Sunday.</i>		
12	Monday	....	Mr. Treacher Collins's Lecture at Royal College of Surgeons. Medical Society, 8.30.
13	Tuesday	....	Medico-Chirurgical Society, 20, Hanover Square, 8.30.
14	Wednesday	....	Mr. Treacher Collins's Lecture at Royal College of Surgeons. Dermatological Society, 8.30.

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. II., No. 2.—FEBRUARY, 1900.

CONSULTATION HOSPITALS.

OUR hospital arrangements as at present constituted make no provision for "consultations" of the kind which patients who can afford fees so commonly obtain. With the latter class it is an everyday matter to take a note or card of introduction from the family adviser, obtain an opinion from a consultant, and remain under treatment at home. The plan works well, and there seems no good reason why it should not be made practicable in the case of the poor also. In their case at present, if further assistance is desired, the home practitioner can but say, "You had better go to a hospital"; and he knows full well that he must forego all further interest in his patient. Many reasons may be suggested why he may not wish to do this. It may be that he does not desire to wholly lose sight of an important case; it may be that he does not wish to subject his diagnosis and treatment to impersonal criticism; and it may be that he has a pecuniary motive, not perhaps large, but still real, for desiring to keep his patient. For any one of these reasons, or for all of them, the time for consultation may be delayed and the patient's interests may suffer. The patient may also lose in another way. In many cases what is wanted is only a diagnosis and suggestions for treatment; and that the gift of drugs, when coupled with the requirement to attend once a week and lose half a day in the waiting-room, may be the reverse

of a boon. The diagnosis once given, all the rest follows, and the treatment may often be carried out, not only as well but far better, at the patient's home, under the eye of the family practitioner. It is, of course, to be granted that gratuitous advice may now be obtained almost for asking, for every practitioner has his friends to whom he can appeal in case of need. This, however, is a matter of favour. There are no special arrangements for it, it cannot occur often, and when it does it is probably often with a feeling of suspicion on the part of the consultant that a fee has been unduly withheld. If, as is sometimes done, such private gratuitous consultation is sought at a hospital, it is an intrusion on the time of the consultant, who ought whilst there to be attending to other duties.

It would probably be a great advantage alike to the public and the profession if Consultation Hospitals, or Consultation departments in our large hospitals, were common. They would tend to bring the several ranks of the profession into closer harmony; they would save the time and money of patients; and, above all, they would conduce to more correct diagnosis and more efficient treatment. It has always been the proud boast of the profession of medicine that it makes no difference between rich and poor, but gives of its best to all. Now in respect to facilities for consultation, the rich, as has been already said, have a very definite and great advantage over the poor, and this reform would remove the injustice and place matters on a more equal footing. As regards details, it may be suggested that in consultation departments the patients should bring with them a note or card of introduction from the family practitioner, or should even be accompanied by him, and should receive from the consultant a written opinion and prescription if necessary. Future attendances should be dependent upon the nature of the case, and should be arranged for or not according to circumstances.

There will be those who will suggest that this scheme would open another door to the abuse of medical charity; and in reply to them it is to be fully admitted that it would need to be safeguarded. The interests of the family practitioner would not usually be endangered, but it is possible that in a few instances those of the consultant might be. Now and then a patient who might have managed to afford a fee would take advantage of the opportunity offered and go with his surgeon or take his surgeon's card to a hospital consultation. When

we remember, however, that these consultations would be more or less in public, and that the patient would be obliged to make his surgeon an accomplice, it may surely be assumed that imposition would be infrequent. Under the present system the patient eludes the family practitioner and slinks off to the hospital in shabby dress unidentified by any one. That kind of deception would not be possible, and the amount which any other would attain would probably be exceedingly small. The extent of damage to the patient's self-respect—the pauperising effect—would be much less than under the present system. It is, however, on this point to be freely admitted that it is part of the proposal to admit for gratuitous consultation a certain class somewhat above that usually esteemed eligible for hospital treatment. It is thought that there are some who being just able to pay their way under ordinary circumstances—married clerks and shopmen, fathers of large families, and other persons of strictly limited incomes—who do and ought to pay for the services of their family advisers, to whom yet the fees of a consultant are out of the question. It is in this class especially that consultations are injuriously postponed. The two guineas cannot be afforded, and the case drags on until at length there is nothing for it but to accept the hospital bed.

Our argument proceeds on the assumption that in all classes of society cases are numerous in which early consultations are very desirable, and are an advantage to all concerned. In urging that arrangements should be made to facilitate the obtaining of them by certain classes to whom they are now not readily accessible, we have in mind such maladies as cancer in its early stages, injuries to joints and nerves, and many forms of disease of the eye and skin. The experience of every medical man will, however, leave him at no loss to recognise that there are innumerable cases in which the friendly interchange of opinion is helpful alike to patient and doctor.

The fact is indeed too obvious to need to be insisted upon, and it may be urged that it bears with especial cogency in the case of those residing at a distance from our great medical institutions. The facilities for cheap journeying are now great, and, so far as the obtaining of a metropolitan consultation are concerned, the residents in our villages are now at no great disadvantage. Funds may easily be found for a single journey, but it would be otherwise if repeated attendances were required, as under our present system.

It may be suggested further that at a Consultation Hospital arrangements might easily be made for special cases by which it should be secured the patient should have the advantage of special advice, or even for the conference of several authorities. Our present arrangements, although in the main excellent, do not adapt themselves sufficiently in these respects, and it may often happen that a patient gets under the treatment of a very able physician, but still not the one best suited for his case. The hurry and overwork which our present out-patient departments (some of them enormously overgrown) involve would also be avoided. These are but too often so great as to make not only clinical teaching impossible, but to render it very difficult for the physician to give adequate attention to individual cases.

Those familiar with the plan of our Polyclinic will not need to be told that in what we have said above we are advocating what is there adopted. Such experience as we have had leads us to think that it will work well. Indeed, so confident is our faith in the superiority of consultation arrangements over the old methods that we venture to predict that before another half century has passed all our large medical charities will have adopted them.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON A CASE OF MYOPATHY.

BY W. M. ORD, M.D., F.R.C.P.

Tuesday, November 14th, 1899.

GENTLEMEN,—To-day we are very fortunate in having two cases particularly suitable for consultation sent up from St. Thomas's Hospital. Both have been carefully investigated, they are both cases of very decided interest, and there is room in each for some difference of opinion.

CASE I comes up with the title, "Myopathy." I may note first that he prefers to stand. You will see the bearing of that later on. His age is 40, and he is a clerk. The following is the history past and present (I have seen him for the first time in the last ten minutes):—

Family History.—No evidence of similar disease in any members of his family is to be obtained ; all have been extremely healthy.

Present Illness.—The patient has been given to understand that he has suffered from his present complaint from infancy. He could not walk until he was 3 years old. He states that his calves were always large, but that otherwise he was thin. When about 5 years old he had a stone removed from his bladder in St. Bartholomew's Hospital. When 20 years old he had an accident in which he thinks that his right hip was injured by a fall from a trap. He was confined to bed for one month. He thinks that after this his condition of weakness was worse than before, but for the last 10 years or so there has been no alteration. Fifteen years ago he suffered from pain in one loin and was told that there was something wrong with his kidney. Seven years ago was confined to bed for one month with "influenza." He states that with effort he can walk a mile, but does not often do it. He can serve customers in a shop but cannot lift things from the floor, and often falls down when walking.

Present Condition.—The mental condition is perfect. There is no weakness of the muscles of the face, eyeballs, mouth, or neck.

When he attempts to stand erect there is marked lordosis, and in addition the sacrum is thrown backwards, pointing to weakness of the erector spinæ and also of the glutæi. When sitting down the lordosis largely disappears. He prefers to use the left leg to stand upon, and is always in unstable equilibrium. He rises from the floor or from a chair by "climbing up his thighs." His walk consists of an

extraordinary waddle, the trunk being brought over first one and then the other hip; the legs are swung forwards, partly by their own weight and much abducted, possibly on account of a certain amount of pes equinus, and partly from failure of the adductor muscles to act. The only muscles which are at all large are the muscles of the calves, the peronei and the deltoids. The others are all more or less wasted. The only strong movement in the lower limb consists in pointing the foot and toes. All the other movements at ankle and knee are very weak. There is also a fair power of flexing the thigh on the pelvis by the ilio psoas. There is practically no power in the adductors of the thigh, and very little indeed in the quadriceps extensor cruris, or the hamstrings. The affection of the legs is symmetrical, also of the thighs. The glutæi are very weak, and to a certain extent wasted. No evidence of accident to the right hip. Legs almost of equal length. No dislocation.

In the arms the only muscle of any strength is the triceps. The biceps is particularly weak. The supra- and infra- spinati are wasted. The lower part of the pectoralis major has practically disappeared on each side. The deltoid muscles, though prominent, are very weak. The latissimus dorsi is also very weak. The trapezius is good. The arms show over-extension at the elbows. Respiratory movements are mainly but not exclusively abdominal. The upper part of the chest appears flattened owing to the muscular wasting.

Sensation.—Appears normal everywhere.

Reflexes.—Superficial reflexes are normal. The knee-jerks are not present, but occasionally during the attempt to elicit them there is a faint contraction of the quadriceps, insufficient to move the leg. The patient states that sexual desire and power are present. Control over sphincters normal. Pupil reflexes normal.

The urine is neutral, specific gravity 1020. No albumen and no sugar present. The bowels act normally. No constipation, and it may be noted that the muscles of the belly wall seem in very good condition. No visceral lesion discovered.

Electrical Reactions.—The reaction of all the weakened muscles and, to a less extent, of the calves, deltoids, peronei, to both the constant and interrupted currents are very much diminished. There is no true reaction of dégénération. No fibrillar twitchings are present. No ataxy or tremor. Temperature normal.

[For these notes I have to thank my friend, Dr. C. R. Box, Resident Assistant Physician, St. Thomas's Hospital.]

Where we have muscular wasting or atrophy, we have, in the first place, to think of it as regards the muscle itself only. We may have what is called a myopathy, an independent trouble in the muscles, not dependent upon affections of the sensory or muscular motor nerves, nor upon affections of the spinal marrow or brain. Next, we have those wastings which depend upon affections of nerves, particularly, we will say, neuritis. Of peripheral neuritis we have a good many forms—those which result from traumatism, or chill; from poisonings, such as those of lead and alcohol; from specific fevers, such as diphtheria and typhoid; and from other more settled affections of the nerves in the immediate neighbourhood of the cord.

Above the nerves, in the spinal marrow, we find more than one cause of muscular dystrophy. Probably the most familiar is that which gives rise to progressive muscular atrophy, and allied with this is, in a certain way, what is called infantile paralysis. A less marked spinal wasting is observed in what is called disseminated sclerosis, and in spastic paraplegia. Of course we find, in connection with long-standing diseases of the cord, wasting of the muscles to a greater extent than can be accounted for by diminution of movement. In another class of cases the wasting of muscles is combined with other dystrophies, such as affections of joints and of skin. Those combinations are, I believe, somewhat dependent upon affection of the spinal cord, but sometimes they appear to be due to reflex propagation of impulses received by the cord from the viscera, and transmitted through the trophic nerves to the various parts concerned. In the case before us, the trophic nerves of the muscles appear to be chargeable.

The patient has a great mass of calf, and relatively small thigh muscles. Obviously, from the way in which he walks, the muscles both in the leg and back of the thigh act very imperfectly, so that he has some little difficulty in bending his knee. When walking, he has to swing round first one leg and then the other in his progress. You observe his lordosis, showing a wasting of the erector spinæ, but one must notice that the nutrition of the skin is very much more generous than in the usual cases of simple myopathy. Moreover, there is a still larger accumulation of fat in the abdominal region, which rather disguises the effect of the wasting. When rising from a sitting or prone position, he is described as "climbing up."

Some time ago we had here a case of pseudo-hypertrophic paralysis. The patient, a boy, was put on the floor, and one saw him climbing up by pressing his hands to knee and thighs, and gradually raising himself to the erect position, making up by the strength of his shoulders for the weakness of the extensors of the thighs. The patient before us has no tremors, either coarse or fibrillar; his knee-jerks, as you have heard, cannot be obtained, although some kind of movement of the thigh is apparent. Supposing the diagnosis to be correct, one would expect there to be no detectable knee-jerks. He cannot cross his legs, even with the help of his arm, hardly, indeed, without extraneous help, and this very clearly shows loss in the power of the thigh muscles. He has no disturbance of temperature, no affection of viscera, clearly

no affection of intellect, and he retains apparently his sexual powers. In fact, wisely or not, he is anxious to get married. So that, as far as one can see here, the whole of the trouble is connected with wasting of muscles, in a man of 40, who is in other ways well nourished and active.

The thing is, how can we narrow this diagnosis down? There is nothing like true paralysis. There is a loss of power, but that is evidently determined by the failure of nutrition in the muscles. There is no affection of sensation; the electrical reactions are simply those which one would associate with diminished muscular volume. There is diminution of reactions both to the galvanic and faradaic current. There is nothing like the diminution of the faradaic sensibility and the exaggeration of the galvanic, which makes the main feature of what is called the reaction of degeneration, which, of course, always means more or less destruction of nerves or centres. That is to say, when we get the reaction of degeneration, we know that there is a profound change in the spinal cord, or in the nerves between the cord and the muscles. We observe that in neuritis and in partial paralysis. Then we think of progressive muscular atrophy, in which we get wasting without the signs of destruction of nerve; that is to say, without the occurrence of either any true paralysis, or the accession of the reaction of degeneration. In that disease the change is essentially in the anterior cornua of the grey matter of the cord, but our patient has none of the tremors of patients who have that mischief, and there is, further, to separate this condition from progressive muscular atrophy, the obvious fact that the muscles of the calves are not only very much more developed than any other muscles of the body, but are developed to an extent which is abnormal in itself.

By the general and symmetrical arrangement in this case, one at once distinguishes it from anything like infantile paralysis. That illness begins in infancy, but is always unsymmetrical. There is paralysis as well as wasting, and there is also the reaction of degeneration; so that I think we can exclude most of the important causes of muscular wasting. Possibly, while I have been thinking the matter over, I have given my attention chiefly to the main points, and I daresay I have omitted some of the causes of muscular wasting.

As far as I can see, this is a case which comes under the general head of muscular wasting of a myopathic nature, closely allied to what

we term pseudo-hypertrophic paralysis, but differing from it in certain ways; most importantly in the fact that the patient is now 40 years of age—an age rarely attained by the subjects of the ordinary form. Next is the fact that his general nutrition, apart from the muscles, is unusually good, whereas in most myopathies it is distinctly bad. Those are points of an unusual character, and make one careful in accepting the diagnosis of myopathy, but it is nevertheless in my opinion a myopathy closely allied to that of pseudo-hypertrophic paralysis, illustrating a principle which we may always respect in diseases of all kinds, and particularly in diseases of the nervous centres. We start in many cases with recognising, as Duchenne did, progressive muscular atrophy, but the exact typical form that he described is constantly departed from in cases that come successively under observation. It is not to be expected that, with a general lesion that the microscope will not reveal, there should be a universal distribution appropriate to every case, or a local affection present in every case. I suppose that is still more acutely seen in the disease which Charcot described as amyotrophic muscular paralysis, where there is, as you know, in all probability atrophy both of the anterior horns of the cord, and of the lateral columns together. His typical description, made with his usual eloquence, stamped the disease upon one's mind. But the more one sees of it, the more one knows that hardly any case met with exactly corresponds to the type; and therein exists the beauty of the study of disease. It is in following out each case in relation to the type that we learn many new things. What a long time it took for people to recognise the fact that when a man had right hemiplegia he had aphasia, and when he had left hemiplegia he had not. The hemiplegia was noted, there were typical descriptions of it, but it was only within our lifetime that the fact of the aphasia being connected with the affection of the left side of the brain became recognised. The patellar reflex is absent in our patient, and there are no contractions of stimulated fibrils to be felt; probably they do exist, but they are inadequate to the production of the phenomenon.

We now have to consider what are the cases in which knee-jerk is not obtained: general paralysis, peripheral neuritis of various kinds, tabes dorsalis, and certain cases of extreme nervous weakness. I do not think that this can be classed with those absolute cases of no knee-jerk. As to an injury at birth bringing about the trouble, I do not

think there are any experimental observations to support that idea, and we may remember that pseudo-hypertrophic paralysis frequently attacks two or more members of one family.

With regard to treatment, I think I should employ a steady course of mild galvanism, and certainly massage. Many years ago I had the opportunity of studying cases of pseudo-hypertrophic paralysis, and I had reason to think that they depended upon something like hyperplastic inflammation of muscles, in which the connective tissues were increased at the expense of the fibres. I still believe that to be the essential part of the process, and I should think that in the present case, when the hypothetical acute condition has passed away, massage would be most likely to be of help, and one is doubly anxious to help a man who has survived the earlier dangers of this kind of illness.

(To be concluded.)

ON TUBERCULAR CAVITIES, THEIR MODES OF FORMATION AND OF CONTRACTION.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

GENTLEMEN,—After a lung has been attacked with tuberculosis, either the tubercular masses remain more or less quiescent, or they undergo fibrosis, or again, what is more usual, they soften, and communicating with a bronchus by ulceration, are expectorated, thus forming a cavity, which from the date of its formation becomes a secreting surface, giving rise to cough and regular expectoration; these continue until the secreting surface becomes obliterated and the bronchus leading to the cavity blocked. A number of cases have been selected to illustrate certain clinical and pathological features of cavities. In the first place attention must be drawn to the position of cavities, or in other words, to the relative liability of different parts of the lungs to excavation. Dr. William Ewart's well-known *post-mortem* statistics from the Brompton Hospital showed that in 304 cases of phthisis—

Excavation existed at the apices in..	..	..	282
„	„	in the dorso-axillary region	.. 227
„	„	„ mammary region	.. 189
„	„	„ sternal region	.. .. 61
„	„	at the base	.. .. 32

This shows a greater liability of the apices to excavation, for which many conditions favourable also to tubercle formation are answerable: such as the weak respiratory movement at the apices, and the consequent imperfect ventilation of the upper lobes; also the weakened condition of the vessels of the part, and the consequent stasis of blood in them.

The comparative immunity from excavation of the base of the lungs is due to the free expansion of the lower lobe by the inspiratory action of the diaphragm, the existence of such action being proved by the presence of blood residues in the lower lobe, and not in the upper one, after hæmoptysis. Some authorities are so convinced of the influence of the diaphragm in preventing the localisation of tubercle and

excavation in the lower lobe that they maintain that basic cavities in tuberculosis are due to pleuritic adhesions interfering with the free movements of the diaphragm and thoracic muscles.

Many classifications of cavities are possible, but the first obvious one is that of *primary* and *secondary*, a distinction of great importance.

A primary cavity is formed by the breaking down of a tubercular mass; a secondary one arises by infection from a primary cavity and is produced as follows:—In an apex cavity of some size, where the secretion is abundant and the power of ejecting it feeble, the bacilli-laden secretion is raised by coughing to a point where the bronchial tube leading from the cavity joins another bronchus coming from another lobe or lobule. Part of the sputum is carried successfully into the main bronchus, trachea, and mouth, to be expectorated, but part falls back into the adjoining bronchus and is drawn by the inspiratory efforts into its ultimate radicles, and there sets up fresh centres of tuberculisation, forming, according to Dr. Ewart, tubercular masses on the distal side of the bronchial radicles.

These break down in time into cavities, which become connected with the adjoining bronchi, and thus is formed the secondary cavity. Secondary cavities have no lining membrane, and are to be found in those parts of the lung where infection from other cavities are possible.

The distribution of the bronchi naturally determines the position of secondary cavities, and it is owing to this that dorso-axillary and mammary cavities are formed, both of which are apparently due to infection from apex cavities. The dorso-axillary cavity is generally the result of infection from the ordinary upper lobe cavity, which gives rise to cavernous sounds between the first and third ribs of the same side; but it is not uncommon to find a cross infection, and an apex cavity of one lung may give rise to a dorso-axillary cavity in the opposite lung. This particular form of infection has been explained by the position of the patient in bed. If the cavity be in the left upper lobe, and the patient lies on the right side, he is more likely to get a secondary cavity in his right dorso-axillary region than in his left, and *vice versâ* if he has a cavity in his right upper lobe and lies on his left side the left dorso-axillary region may become infected.

The mammary cavity is generally a secondary one, though its method of formation is not so clear as in the case of the dorso-axillary cavity. Many of the basic cavities are secondary to apex ones. We must bear

in mind the possibility of secondary cavities, and in our examinations go carefully over the portions of lung likely to be infected from a primary cavity with a view to detecting them. The dorso-axillary cavity is often overlooked, and many basic ones escape notice for a long period.

Another lesson to be learnt is that we should regulate our patient's position so as to render expectoration as easy as possible, and to prevent the chance of the sputum passing down both bronchi, and thus giving rise to new tubercular centres.

In carrying out the open air treatment, which requires a patient to lie down for a certain number of hours a day in the open air, we must place our invalid on the couch with the shoulders raised, in fact, in a more or less sitting posture, supported by a sloping back.

Other classifications of cavities would be the *active progressing* cavity, where ulcerative processes are proceeding rapidly in the walls and causing extension, the *chronic quiescent* cavity, the walls of which do not appear to be the seat of active change, and the secretion is purulent, moderate in amount, though containing tubercle bacilli. These last cavities appear to be shut off completely from the rest of the lung, and to resemble localised abscesses; many patients who have cavities of this sort are hardly aware of their existence except for the morning cough and regular expectoration of a few pellets of sage-like sputum.

Far different is the large *tinkling cavity* so often present in advanced cases. Such cavities are extensive enough to occupy either a whole lobe or nearly the whole lung, leaving in some cases little but pleura, and a few bronchi and shreds of tissue and bundles of vessels. They give rise to nearly the same physical signs as are found in cases of pneumothorax. The excavation of a whole lobe is not uncommon, and the large amount of air present with fluid is the cause of the tinkling sounds heard on cough. Patients with tinkling cavities may live a long time, provided there be no fever, that expectoration is possible, and that profuse hæmoptysis does not take place, such hæmorrhage being generally due to the rupture of aneurysms or ectasias of branches of the pulmonary artery. Also provided that the lung surface suffices for their respiratory needs.

Having discussed the formation and extension of tubercular cavities, let us consider their modes of contraction. The fact of a cavity contracting proves the existence of a certain amount of fibroid growth in

the lung, arising either from the interlobular tissue, or from the pleura, or from fibrosis of the tubercular masses. In this way we get bronchi shortened and their walls infiltrated, and as the lung tissue is more and more involved from the ingrowth of fibrosis we find a shrinking of the whole lung and an approximation of the walls of the cavity to each other. The walls approach and in some cases join, but rarely do they form a cicatrix; more commonly a long, irregular, narrow sinuous channel, broken in parts by adhesions of the fibroid walls, and containing mortar-like material or caseous masses, and unconnected with any bronchus.

When a cavity in a lung contracts, the contraction takes place towards a fixed point. If the pleura be adherent over a portion of the lung contraction will be towards the adhesions, and this accounts for the apparent closeness of the cavernous sounds to the ear in many instances. If there be no adhesions the contraction of the cavity will be directed towards the root of the lung—the fixed point, and it is during this process of contraction that the remarkable vagrancy of the cavernous sounds is noted. In apex cavities contracting towards the root of the lung the cavernous sounds become gradually less distinct in the first and second spaces, and audible in the supra-clavicular and supra-scapular regions, then disappearing from these they are audible in the inter-scapular region, and finally vanish altogether. Their disappearance must probably be accounted for by the probable closure of the bronchus leading to the cavity, in the contractile changes, and not necessarily by the obliteration of the cavity itself. The symptoms of a contracting cavity are as follows:—The cough diminishes and becomes paroxysmal, and the expectoration scanty, and sometimes slightly offensive, though always purulent, and generally containing a few tubercle bacilli. The breath is sometimes shorter, though this depends on the size of the cavern and the extent of lung surface involved. There is considerable gain of weight, sometimes as much as a stone, and great improvement in appearance.

The changes in the thorax are most interesting, but vary according to the situation of the cavity. They may be classed thus:—

1. *Changes in the Chest-Wall and Spinal Column.*—Flattening of the chest-wall overlying the cavity and diminution in the thoracic circumference at this point is very common, especially if there be pleuritic adhesions. This flattening, which generally occurs between the first and

fourth ribs on either side, is sometimes the first sign to attract the medical attendant's attention to the lung changes, though it is not by any means an essential feature of cavity contraction, and it is often entirely absent. The flattening is accompanied by diminished mobility, and reduction in the circumference amounting to from 1 to 2 inches. Where large cavities contract there is often depression of the shoulder, and I have shown in more than one instance curvature of the spine towards the affected side; in one case this followed the contraction of a tinkling cavity.

2. *Changes in the Lungs.*—When the contracting cavity is in the right upper lobe, the middle lobe is drawn upwards, the contracting lobe passing towards the root, and sometimes both lower and middle lobes undergo hypertrophy, and the middle lobe taking the place of the diseased upper one, the dulness and cavernous sounds, formerly present in the right upper front, are replaced by resonance and harsh breathing. It not uncommonly happens that the diaphragm and liver are drawn up, and the limits of the hepatic dulness is detected higher than normal on the right side.

In most cases of right apex cavity contraction the compensation is accomplished by the left lung being drawn across the median line, in front of the retreating right one, to the extent of 3 or 4 inches, this extension being clearly traced by the line of resonance, or, it may be, of hyper-resonance, which contrasts with the dull note when the chest-wall overlying the fibroid lung is touched. I remember a case where a cavity formed in the right lung contracted, and the lung, undergoing extreme contraction, was reduced to the size of a fist, and retreated to the back of the thorax, against the spinal column. The left lung became enormously hypertrophied, and occupied nearly the whole of the right side of the chest; but, curious to say, becoming affected with tubercle, a cavity formed in much the same position as regards the thoracic wall as the first cavity had occupied, and so the remarkable spectacle was presented of two lungs, each with a cavity, holding in succession the same position in the thorax. All this was verified by *post-mortem* examination, and the case was published by me years ago. The contraction of cavities in the right lung gives rise to displacement of the heart, and the cardiac dulness is sometimes to be detected over the lower sternum, and the cardiac impulse to the right of it. But the most remarkable changes in the cardiac position occur

when the cavity is in the left upper lobe, for here the raising of the cardiac impulse is often the first indication of the contractile changes in the cavity. The heart's impulse is found to follow the retreating lung step by step, the impulse being felt successively in the fourth and third spaces, passing first to the vertical nipple line, and then outside it, and reaching in some cases the axilla. The heart's apex, as Dr. Pollock has shown, sometimes describes an arc of a circle, the aorta being the fixed point, and consequently the centre, and this twisting of the aorta may give rise to a systolic murmur. The retreating lung also lays bare the pericardium, and the pulsation of the auricles can often be seen in the second space. The left lower lobe is sometimes drawn up, but not so commonly as the right middle and lower lobes, and compensation is more generally accomplished by a drawing across of the right lung, which sometimes extends to nearly the left vertical nipple line. The diaphragm and stomach are also drawn up, and the stomach note is to be detected as high as the fourth rib. The diminution in the circumference of the left side of the thorax occurs to the same extent as on the right.

When cavities have contracted in the manner described, what is the effect on the patient? As a rule the effect is excellent, and the tubercular disease may be said to be arrested. But the fibrotic processes which have stayed the progress of tubercle may go too far, and may obliterate much of the remaining respiratory surface, and obstruct the flow of blood through the blood vessels and lymphatics, thus giving rise to cardiac dilatation and dropsy, and to serious renal changes. Such patients die of heart disease, and dropsy, and renal disease, though, perhaps, not of tuberculosis. The clinical history of cases of contracting cavity, though on the whole pointing towards permanent arrest of tuberculosis, unfortunately admits of certain unfavourable terminations. Fibrosis of one lung does not prevent fresh tuberculosis of the other lung, if the patient's constitutional condition becomes depressed, and unfavourable. A cavity which has contracted may become the seat of retrograde changes, and such extensive breaking down of the lung may take place that a larger cavity may be formed than the original one. This is generally caused by suppuration taking place around the fibrotic mass, and the whole fibro-tubercular centre being expectorated. These are not common occurrences, but they must be borne in mind as possibilities.

ON THE ADENOID FACIES, PERI-TONSILLAR ABSCESS, AND OTHER TOPICS.

BY ST. CLAIR THOMSON, M.D., F.R.C.S.

The Adenoid Facies.

A BOARD School teacher, a young woman of 19, was shown to illustrate this type. Although a tall and well-built young woman, she showed the open mouth, the pinched nose, the paretic *alæ nasi*, the flattening and absence of lines over the upper maxillæ, and what Meyer (the discoverer of Adenoids) had called the "veiled look" below the eyes; all of these symptoms going together to make up the "adenoid facies." This type is so common and well marked that cases could be diagnosed across the street. In the present case confirmation of the condition was found in the undeveloped alveolus of the upper jaw, and the crowded condition of the upper teeth, which last was probably a consequence of this arrest in growth. Further evidence was to be obtained from the altered tone of the patient's voice, the so-called "dead" or "nasal" speech, or absence of resonance, and the faulty enunciation of the letters *m* and *n*. To detect this defect in speech Dr. Thomson had found it useful to make children repeat such words as "Clapham Common." But the type of speech was almost as characteristic as the facies, and in the majority of cases a correct diagnosis could be made merely from hearing the patient speak, and without seeing him. The voice of the adenoid newspaper boy was almost a characteristic of our streets, and should be contrasted with its marked absence in such climates as the South of Italy, where adenoids were comparatively rare.

It was the *voice trouble* which had caused this patient to seek advice. Although she had passed a couple of years as a pupil teacher and two more in college, no special examination had ever been made of what was the most important part of the body to a professional voice-user, viz., the upper air-passages. Consequently, although this young woman's voice had been equal to the requirements of ordinary life, it had broken down in a very few months, when she had to teach a class of some 50 or 60 infants. Having no resonance in her voice—owing to the blockage in her post-nasal space and consequent interference with

the nasal air-way—she had been forced to shout, and she was now hoarse from chronic hypertrophic laryngitis. The treatment was, of course, to remove her adenoids at once, give rest to her voice, and then have her properly trained in breathing, voice production, and elocution.



FIG. 1.—Characteristic Expression, Attitude, and Deformity of the Chest met with in Adenoids. (From a photograph in the possession of Dr. StClair Thomson.)*

This would certainly improve her, but at the age of 19 the bones of the face were, to a large extent, completely ossified, and it was sad to think that this teacher would be handicapped throughout her career by the

* For the loan of this block the Editor is indebted to Messrs. Cassell and Co.

narrowness of her nasal fossæ and post-nasal space. Had the trouble been detected in good time this might have been spared her.

But although to this group of features (as illustrated by the photograph of another case of Dr. Thomson's, Fig. 1), the name of "Adenoid facies" has been given, it was pointed out that it really should be called the *type of early nasal obstruction*, for exactly similar symptoms would be manifested as a result of any chronic obstruction to nasal respiration in early life, while the permanent teeth were appearing and the bones of the face ossifying. Still, in a very large majority of cases, this type of face was characteristic of either the actual presence of adenoids or of the results left after the disappearance of hypertrophy of Luschka's tonsil.

At the same time it was highly important to bear in mind that a patient might be suffering markedly from some of the consequences of adenoid growths and yet show no trace of this "adenoid facies." Take, for instance, the resulting *affections of the ear*. There was, in his opinion, no relation whatever between the size of these post-nasal growths and middle ear trouble. In some of the largest growths—those causing the most exaggerated "adenoid facies"—the ear was frequently quite unaffected; whereas cases were met with in which extensive damage to the ear was evidently the result of the presence of adenoids, so small as to cause none of the features which have been referred to as characteristic of this type. On the other hand, again, a patient may present all the facial characteristics of naso-pharyngeal adenoids, and even the secondary results, so often associated with their presence, and yet his post-nasal space may reveal no increase of adenoid tissue. This has been excellently summed up by Castex when he said: *On peut paraître adenoidien sans l'être, comme on peut l'être sans le paraître*.

The first half of this conclusion—that the "adenoid facies" does not always mean the presence of adenoids—is illustrated in the physiognomy depicted in Fig. 2. In this we will at once recognise all the points which are sometimes loosely referred to as "typical" of post-nasal growths. The mouth is wide open, revealing crowded and irregular teeth; the upper lip is hitched up, while the lower one is drooping and expressionless. The nose is thin and the nostril is reduced to a narrow slit, while the alæ are not well defined, and there is evident atrophy of the elevators of the upper lip. The record of the case (published by Escat*) shows that the hard palate was highly arched, the thorax

* *Archiv. Internat. de Laryng.*, No. 3, 1896.

narrow and laterally compressed, and that the patient had been a mouth-breather since childhood, and snored lustily at night. It is on just such a group of symptoms that an off-hand diagnosis of adenoid growths is frequently made, and while agreeing that in an immense majority of cases, especially in children, this diagnosis would be confirmed on further examination, still the record of cases, such as the one above represented, proves that the appearances are, as has been already remarked, not pathognomonic of adenoid vegetations, but only of nasal obstruction.

A further examination, both by mirror and forefinger, of the individual represented in Fig. 2 showed that the mucous membrane of his nose



FIG. 2.—Congenital Stenosis of the Nasal Fossæ and Naso-Pharynx (after Escat)

and pharynx was entirely free from any chronic disorder; neither catarrh, nor enlarged tonsils, nor adenoid vegetations were present. This illustration, in fact, presents the deformities of the face which are associated with *congenital stenosis of the upper air-passages* occurring in a hereditary degenerate. His facial angle only measures 60° ; he is microcephalous, the forehead is depressed, and the face, in profile, is relatively large. The sketch further reveals, as stigmata of degeneration, the receding chin, the misshapen ear, and the lobule adherent to the cheek. He is, in brief, an imbecile, subject to epilepsy, with delirium consequent on the attacks, so that his friends requested his seclusion in an asylum at the age of 22, the age when this drawing was made.

Peri-tonsillar Abscess.

A young man was shown convalescent from acute tonsillitis. Dr. StClair Thomson expressed the opinion that all "quinsies" pointed and burst in the peri-tonsillar region, and not through the substance of the tonsil itself. Small, generally discrete, collections of pus might form in the several follicles of the adenoid tonsillar tissue, but these opened separately on the surface, and the symptoms were less acute than, and of a different character to, those of a quinsy. The symptoms of the latter were too well known to members of the Polyclinic to need description, and he proposed to limit his remarks to the *treatment* indicated when pus had evidently formed. The usual treatment recommended was incision with a bistoury, and, not having observed that the pus collected and pointed outside the tonsil, it was usually recommended to protect a bistoury with either sticking-plaster or a cigarette paper, up to its point, and then plunge the latter into the substance of the tonsil. In the majority of cases the pus was not struck, but the attendant generally comforted the patient with the assurance that the bleeding would do good, and a few days later the "matter" would, as the patient expressed it, "burst of itself." This was such an unsatisfactory condition of throat surgery that a recent writer on therapeutics had referred to incision of the tonsil as painful, useless, and therefore to be discarded. As undoubtedly pus did form in these cases—sometimes in large quantities—there must be a proper method of giving relief to it if we studied carefully where to find it, and how to evacuate it. Firstly, therefore, with regard to the location of the abscess, it was nearly always above the tonsil, in the region of the supra-tonsillar fossa, and it bulged forward the corresponding half of the soft palate. If a line were drawn horizontally along the base of the uvula, and another were drawn vertically parallel to the anterior faucial pillar, the point where these two imaginary lines would intersect would be found to be in the soft palate, quite above the tonsil, and to be the commonest site of suppuration. Secondly, as to the method of reaching this collection. The knife should be discarded. It was unnecessary, it frightened the patient, and if it failed to relieve (as it generally did when the tonsil was directly attacked), the patient's confidence was shaken. He preferred the forceps represented in the illustration on next page. They are a modification of those known as

Lister's sinus forceps. In using this instrument the region to be punctured might be painted over first with a little cocaine. Under the guidance of a good light the forceps were introduced, with the blades closed, and pressed gently against the soft palate at the site indicated. If they were over the point where the abscess was "pointing" a boggy feeling would be transmitted to the surgeon's hand, and in that case he should firmly push the closed forceps into the suppurating cavity. The pus, often very foul, would pour out, and

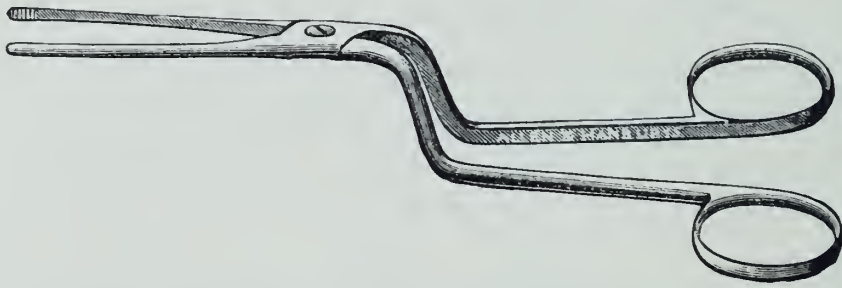


FIG. 3.—Forceps for opening Peri-Tonsillar Abscess.

the patient's head should be quickly thrown forward, that it might not pour into the larynx. At the same time the forceps are withdrawn from the abscess cavity, but with the blades widely opened (on Hilton's principle), so as to leave a free opening for drainage. If this boggy feeling was not marked the point of the forceps should be gently pressed round the region indicated. They were not sharp, so that they would hardly enter healthy tissue, but at the same time were sufficiently pointed to break through, with the application of very little force, the layer of necrotic tissue which separated a collection of pus from the surface. The forceps should not be partially withdrawn and then thrust forward with a stabbing action. Such a procedure only frightened the patient, and was unnecessary. Finally, even if in the hands of the inexpert the abscess was not "struck" with this instrument, the patient was not as much alarmed as by the useless exhibition of a knife.

Personally, Dr. Thomson had used these forceps for years, in common with most of his colleagues, and he had seldom failed to find and evacuate peri-tonsillar abscesses with them. The forceps would also be found useful for removing foreign bodies from the nose, and for a variety of purposes in treatment and minor surgery.

Empyema of the Maxillary Sinus.

Three cases were shown together as illustrative of suppuration in the antrum of Highmore. The description of this condition, which is found

in the older text-books, is 'rather fantastic, and must be abandoned. It gives the classical symptoms of redness, swelling, and pain as characteristic of acute suppuration in the antrum. But acute suppuration rarely gives rise to such symptoms, and it is very probable that acute osteo-myelitis, in connection with dental mischief, was mistaken for acute sinusitis. The latter frequently passes almost unobserved as part of an ordinary acute rhinitis, and it is the chronic, or latent, suppuration in the maxillary sinus which most commonly calls for attention. This is not an uncommon affection, especially in adults, and may arise from either a dental or a nasal origin.

The symptom for which a patient most commonly seeks advice is a discharge from the nose, usually one-sided, although, of course, it is possible for both sides to be affected at the same time. This discharge of pus may flow backwards into the throat, and hence in some cases the patient only complains of cough or digestive troubles. At times more remote symptoms—such as headache, tinnitus, vertigo, neuralgia, migraine, mental depression, intermittent albuminuria, slight evening rise of temperature, &c.—are the only ones that present themselves. Tenderness over the maxilla is rather an unusual symptom. The discharge from the nose may be yellow, greenish, creamy, or clotted. To the patient it is as a rule very offensive, while it can only exceptionally be perceived by those near him. This cacosmia helps to distinguish the affection from ozæna, in which the patient is quite unconscious of the repugnant odour which he exhales. The detection of pus in the middle or inferior meatus of the nose is the first objective symptom. In the absence of a foreign body and of any gross lesions, such as syphilis, tubercle, or new growth, pus in the nostril—especially if one-sided—indicates suppuration in one of the accessory cavities. If in the middle or inferior meatus, it must come from one of three sinuses—the maxillary, frontal, or anterior ethmoidal. In the diagnosis the three chief methods of differentiation are by transillumination, puncture, and catheterisation. These three methods were then illustrated.

As to treatment, he recommended the trial of simple drainage by perforation through the alveolar border and washing out, whenever an empty tooth-socket or diseased tooth could be found on the affected side. This cured a considerable number of cases, and recourse could always be had later to a more radical operation if required.

ON HILLIARD'S LUPUS.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—Before our patient comes into the room I wish to show you two or three portraits. One of them reproduces so exactly the features of the skin disease which you will see directly that it might be supposed to have been sketched from her arm. The malady in question consists in the development of a long, rather irregular streak, extending from the thumb in some cases, and from the little finger in others, the whole length of the forearm and upper arm as high as the shoulder. I have never seen it go higher than the shoulder, but in one very remarkable case it was associated with similar patches in the face. This latter case was the first, I think, in which I ever observed the affection. Its subject was a boy named Hilliard, and after him, provisionally, I purpose to name the disease; and as I now feel sure of my ground in considering it a form of lupus, we will, if you please, call it Hilliard's lupus. In the first instance (see *Clinical Lectures*, p. 311 *) I called it lupus marginatus, but as other forms of lupus sometimes have abrupt margins, this adjective may become more or less misleading. "Hilliard's lupus" can mislead no one. To understand what it refers to, it is needful to have seen the portraits which illustrate Hilliard's case, and to have glanced over the narrative, and those who have done this will

* For the readers' convenience I subjoin an extract from the lecture referred to :—

"*Lupus marginatus*.—Before I conclude I wish just to mention to you a form of lupus so rare that I have seen but one good example of it, and for which I have ventured to use a new adjective. The beautiful portrait by Burgess, which I show you, will give you an excellent idea of the case. The patient was a slim, delicate looking lad, of about 8 years old. He had had the disease several years. On his face, not symmetrically, but chiefly on the right cheek, were a great number of patches, all abruptly margined and all exactly alike. None of them were either erythematous or sebaceous in the least, but in all a very narrow rim of minute coherent papules surrounded an area of pale thin scar. The papules were almost microscopic, but they were there, and they mapped out the scars much as a border of red colour in a map might mark the outline of a lake. These edges were clearly creeping, that is, they infected the skin next to them, and when the disease subsided a scar was left. Thus, the essential characters of lupus were there, and as the existence of a narrow margin of morbid action was the conspicuous feature the adjective *marginatus* seemed the most appropriate. So little like lupus, at first

not easily misapprehend or forget it. Some of you may, perhaps, be raising in silence a protest against the introduction of new names, but let me ask such to consider that the malady is peculiar and must have a name; and next, that it is by no means proposed to lay the burden of it upon the profession at large. It will be sufficient if specialists and those who take a large and general interest in medical science, and who *ipso facto* have good memories, should know what is meant by that designation. For others it may be quite sufficient to know that in addition to the two main forms of lupus—vulgaris and erythematosus—there are a number of others, of rare occurrence, descriptions of which may be found in books of reference.

Now let me show you the original portrait of Hilliard. In 1870, when it was taken, he was a fair-complexioned lad of 8. His face, as you see, was covered with well-margined patches—resembling islands of various sizes on a map—all of which showed an elevated border of little lichenoid papules, and in the middle of which was thin scar. Some of the patches remind us a little of the discs of lupus erythematosus, but they are on a smaller scale, and there is neither inflammatory swelling or erythematous redness around them. They are evidently aggressive, spreading by contagion of continuity at their edges. Let us note particularly that they are not arranged with bilateral symmetry, but are quite irregularly placed. We will next look at his arm. The skin over the ball of the little finger is occupied by a rough and thickened patch which is raised a quarter of an inch above the level. It is not ulcerated,

sight, was the eruption that I believe no one thought of that malady in connection with it until the several features had been carefully studied. I showed the boy at a meeting of the Medico-Chirurgical Society, and it was suggested by one speaker that it was really lupus erythematosus. But in essentials it was more like common lupus than erythematous lupus, for, apart from the facts that it had tubercles and no erythema, it showed no tendency to observe symmetry, but occurred in irregularly scattered patches. Further, although the patches were plentiful they did not affect the erythematosus positions; there was, as you may see, not the faintest approach to the bats'-wing, the ears were not affected, and, finally, a line of patches occurred in the left forearm and hand, there being none on the right. Lupus erythematosus, if it affects the upper extremities, occurs on the backs of the hands, and never, so far as I am aware, travels down the forearm. I assert, then, that the disease is essentially common tubercular lupus, but, at the same time, I think that its peculiarities are such as to deserve recognition in its name. I adopted the treatment suitable for common lupus—that, namely, of destroying its edges with the actual cautery." See also *Archives*, vol. i, Plates XIII and XIV (at end of volume); see also *British Medical Journal*, 1880, vol. i, p. 652.

but has a certain amount of scale crust which adheres closely and dips into minute depressions in the surface. Running up the ulnar border of his forearm in continuity with this patch, crossing the side of the elbow, and up the front of the upper arm as high as the shoulder, is a streak made up of little patches and crescents and circles, which share



the characters of the disease, as shown on the face and on the hand. When I have told you that Hilliard had had his eruption several years, and that, to my knowledge, it was uncured several years later, I think I have said enough to give you a clear estimate of its peculiarities. I do not know what has become of him, for although I have done my best to trace him I have failed.

Let me show another portrait—it is that of the upper extremity of a lady. Miss N., who is now a well-grown young lady of 24, in good health, but thin, was only a girl of 14 when this portrait was taken. It shows a long streak passing up from the hand to the shoulder, just as in Hilliard's case. The original patch, and still by far the largest one, was on the ulnar border of the hand. The features of the disease are so exactly those just described in Hilliard's case that I need not detail them. I had not myself seen the arm for many years, but by the courtesy of Mr. Wreford, of Clapham Road, I have within the last week had an opportunity for again inspecting it. She had much escharotic treatment for the hand after I saw her, especially by potassa fusa under Dr. Living. These measures entirely destroyed much of the upper part of the band, and have left sound white scar.

The disease, however, remains much as it was on the side of the hand and at several parts of the forearm. It is here rough and nodular, with some tendency to eczematous irritation in cold weather. I do not think that anyone would hesitate to name the patch on the hand as necrogenic lupus partially cured by treatment. It is remarkable that the patches have not advanced materially in any direction. Miss N. believes that the first patch was on her arm near the elbow, and that it very rapidly spread both upwards and downwards to the full extent that it ever attained. As, however, she was then only a child of 6 her impressions on this point may be erroneous. We may take it as certain that it attained its full dimensions in the course of a year, and that there has been no material aggression since. In some places, especially on the border of the hand, the process would appear to be one of keratosis, and narrow lines or little nodules of corn-like structure have been produced. These are so hard that they might be pared with a knife, like corns. Exactly similar conditions are present on the front of the thumb in Mrs. B's case, which you will see directly.

As regards the history of tuberculosis in the family there is not much to be said. One or two great uncles are reputed to have died of phthisis. Our patient is an only child, and both her parents are living and in good health. Her father had one lower limb amputated by Mr. Caesar Hawkins in 1859 for "a tumour involving the knee." It had not been attended by abscesses, and was, he says, quite painless, so that it does not appear very probable that it was of a strumous nature.



We may just give a passing glance at a photograph from the St. Louis Hospital collection in Paris which illustrates the same condition, and then we will look at our present patient.

I am indebted to Dr. Arnold Scott, of Bocking, for the opportunity of bringing this patient before you. She is a woman of about 58, married, and the mother of a family. She is not aware of any tuberculosis on her own side, but her husband died of phthisis, and for the contagionists this may be an important fact. Her own disease began in her hand. On her right hand, as you see, there is a thickened patch of roughened skin over the ball of the thumb, another just above the wrist, and from these there pass up the forearm two narrow bands made up of more or less confluent patches. These bands join at elbow and ascend the upper arm and over the deltoid as high as the acromion. It has been much scratched, and our patient says that it has itched intolerably. As a result probably of this scratching an almost eczematous condition has been induced a little below the elbow and over the deltoid. The upper spots are abraded and one might easily believe that they had been entirely caused by scratching. There is but little more to be said about the case, the conditions are exactly like those in the other patients. Mrs. B. is in fairly good health though a rather delicate looking woman. She has no other skin disease, and the skin of the arm close to the patches is quite supple and free from congestion.

We will now, if you please, consider the meaning of certain facts which are presented to us in common by all the four cases I have adduced. In all with the particulars of which I am acquainted (three of the four), the disease began on the hand and travelled rather quickly from thence up the extremity. In all four, to the end, the patch on the hand was by far the largest and most important. My inference from this is that the hand probably had been infected, and from it by a process of contagion by continuity of tissue the disease of the skin travelled. The first sight impression that a streak must indicate nerve influence is probably wholly illusory. Most likely it is from first to last a tubercular—and, therefore, lupus—affection which spreads in the lymphatic spaces of the skin—mind in the lymph spaces not in the lymph trunks, for it does not pass deeply nor does it cause enlarged glands. The disease at its starting point seems exactly like a common form of lupus necrogenicus, a disease always resulting from inoculation, and which often does cause abscesses in glands. In Hilliard's lupus, however, the disease remains comparatively superficial. It is not improbable, however, that we may find some connecting links. I grant

that it is a somewhat new observation that lymph-space-infection can extend itself not diffusely but in lines. There is, however, nothing very improbable in it. That the process once begun should keep to type and reproduce throughout local conditions exactly similar to those with which it commenced is nothing unusual. It illustrates a general law, the operation of which we witness in all forms of lupus and many other diseases.

In none of the cases was the condition congenital. In three it began in early life, but in the fourth, our patient this afternoon, the woman was past 40 before the first patch on the hand was observed.

If I have succeeded in establishing to your satisfaction my contention that the disease is an infective tuberculosis of the skin—a lupus, in fact—it will not be needful that I should say much as to treatment. The patches should be destroyed by means of some cautery as early and as promptly as possible. This recommendation, however, applies with much greater force to cases in which the patient is young than to those like our present one. In the present instance the disease gives but little trouble, and heroic measures are scarcely demanded. It may, perhaps, conduce to the patient's comfort to use only palliatives.

ON GRANULAR KIDNEY WITH PIGMENTATION OF SKIN, AND OTHER CASES.

BY HARRY CAMPBELL, M.D., F.R.C.P.

GENTLEMEN,—The patient whose case we will take first is a man, aged 64. He has been complaining of shortness of breath and swelling of the ankles lately. Observe the large amount of pigment in the skin of his face. Note, also, that the cardiac impulse is beating outside the nipple line, and is displaced downwards; if you palpate the impulse, you will feel a powerful and deliberate thrust—this is the only absolute sign of cardiac hypertrophy. The pulse gives important indications: the radial artery is thickened, and the pressure of blood within it unmistakably high. Dr. George Oliver's hæmodynamometer, you will observe, indicates a pressure of 180–190 Hg. *mm.*, while the second aortic sound is accentuated. On these data alone we are justified in making a diagnosis of granular kidney, and on further investigation we find our diagnosis to be correct; the patient passes a large quantity of urine, the specific gravity, as you see, is low (1008), and there is a trace of albumin.

I have said that the diagnosis is certain in this case without examining the urine. I should not have made this statement unless the face had been morbidly pigmented. This excessive pigmentation is common in granular kidney, as first pointed out, I believe, by Sir Grainger Stewart. I have several times observed the connection. Sometimes the pigmentation gives a fallacious appearance of health, the skin becoming actually bronzed. I say, if there had been no pigmentation I should not, without the evidence afforded by the urine, have diagnosed granular kidney, though the chances of its being this disease would still be very great. The fact is, an elderly person may present all the cardio-vascular features of granular kidney independently of this disease (Gull and Sutton, Savill). I have now under observation a gentleman, aged 66, who has a hypertrophied heart, thickened radials, and high arterial tension, and whose urine is nevertheless (so far as I can ascertain) perfectly normal—by which I mean that a 24-hour specimen is not only devoid of albumin (this by itself would mean little, seeing that a person with granular kidney may go for years

without albuminuria), but that the specific gravity, output of nitrogen, and quantity of water passed are normal. This patient, I may remark, has had several attacks of epistaxis. Now, it is almost an aphorism that if a person past middle age suddenly develops nose-bleeding, there being no local disease to account for it, he is suffering from granular kidney, or at least from the cardio-vascular changes characteristic of it. It is very fortunate that the hæmorrhage takes place externally in this case, for in this way it is actually beneficial, lowering, as it does, arterial blood-pressure. But suppose the bleeding, instead of occurring externally, took place into the brain, the affair would be a catastrophe instead of a blessing. In cases of this kind we must lower blood-pressure at any cost. In this way we may prolong life for several years, especially where there is no serious kidney disease.

The method I recommend is as follows:—Just sufficient food is to be taken to provide for the energy required by the body, *and no more*, and this in an elderly or old man is much less than is generally supposed; large quantities of water are to be sipped on an empty stomach, little or no liquid being taken with meals; the patient must keep himself warm so as to relax the superficial vessels, and most carefully avoid the sudden shock of external cold—I have several times known cerebral hæmorrhage to result from this; we must save the heart to the utmost, allowing only moderate and gentle exercise; last, the bowels must be kept freely open, and to this end we should push calomel as far as we dare—some of these patients thrive in the most astonishing way on this drug. I not infrequently give potassium iodide, and liq. hydrarg. perchlor. in addition.

Now to return to the patient you have just seen. You heard the accentuated second aortic sound. It is most characteristically heard in granular kidney and aortic aneurysm; when very pronounced, it may sound almost like a hammer striking an anvil, and may communicate to the chest-wall a diastolic shock which may be felt quite easily by the hand. I personally do not place any significance on accentuated second sounds, unless the accentuation is very marked. It is quite common to hear an accentuated second aortic sound when arterial pressure is by no means high.

Another feature in this case I would draw attention to is the œdema of the ankles. This signifies that the left ventricle is beginning to fail, and the capillary circulation to slacken. A failing left ventricle means

a failing capillary circulation, and it is this latter which is the essential cause of cardiac dropsy—the capillary wall becoming abnormally permeable—and not, as was once thought, heightened capillary pressure. For years the left ventricle has been bravely battling up against an abnormally high “peripheral resistance” situated in the arterioles, and some say (as I think erroneously) in the capillaries also, and now it is beginning to strike. Instead of emptying itself adequately with every beat, an excess of residual blood is left behind (some say the ventricle never completely empties itself in systole), and the blood flowing in from the auricle in the usual way, the chamber is distended by an excessive charge of blood at the end of diastole—there is, in brief, excessive diastolic distension. This is the fundamental fact in all cases of cardiac dilatation. Directly the left ventricle fails to adequately empty itself in systole, the process of dilatation is set on foot, and the blood, not being driven onwards in proper quantities, accumulates behind in the lungs and systemic veins.

Now see how serious is this cardiac failure in granular kidney. The available renal parenchyma in the late stages of this disease is very greatly reduced ; it is, perhaps, no exaggeration to say it may be reduced to one-tenth of its original amount, or even to less than this. So long, however, as this restricted renal area is copiously flushed with blood by a powerful left ventricle, it may serve to eliminate the nitrogen and other excreta fairly well, but mark what occurs when the circulation fails : the blood now meanders sluggishly through the renal capillaries, the elimination of nitrogen falls to a dangerously low level, and the patient is in imminent peril of uræmia. Hence anything which causes the heart to fail in granular kidney, such as muscular exertion, or profound emotional disturbance, may precipitate an attack of uræmia ; and hence the vast importance of watching the heart in cases of this disease and doing our utmost to husband its powers. Within the last few days I have seen a good instance of uræmia arising from cardiac failure, and will briefly describe it. The patient was a woman, aged 54 ; she was said to be suffering with asthma, but what distressed her most, and what my opinion was chiefly sought for, was a violent occipital headache. She was a stout woman, and was sitting up in bed breathing with great difficulty ; her lips were blue, and there were anasarca and ascites. It was quite obvious that one had to do with a failing circulation, and I expected to find some long-standing mitral or pulmonary

trouble, but on examining the pulse it was at once evident that an altogether different state of affairs existed; the artery was thickened, and the blood pressure, as tested by the finger, manifestly high; Oliver's instrument showed it to be over 200 Hg. *mm.* Now in failing circulation from mitral or pulmonary disease we occasionally observe a fairly high radial pressure, but never such a pressure as this. The state of the pulse, without any further examination, sufficed to make a diagnosis of granular kidney practically certain. Kidney disease, increased peripheral resistance, hypertrophy of the left ventricle, dilatation of it, engorgement of the lungs, with probable bronchitis, engorgement of the systemic veins, anasarca and ascites, failing circulation through the kidneys, uræmia producing violent occipital headache and asthmatic paroxysm (thus aggravating the trouble due to pulmonary engorgement and causing cyanosis)—these links in the morbid chain were at once suggested by the pulse, and subsequent examination of the case proved my interpretation to be correct. The urine was nephritic; there was albuminuric retinitis, and there had been uræmic vomiting. One word as to the treatment: I ordered the application of ten leeches over the liver, the flow of blood from the bites to be freely encouraged; five grains of calomel, *statim*; a mixture containing digitalis, strychnine, and carbonate of ammonia; a diet limited to small quantities of milk. The patient got prompt relief from this treatment; the headache entirely disappeared, and the breathing became perceptibly better. But it is, of course, obvious that in such a case as this you can at best patch the patient up for a time.

I have yet two other cases to bring before you.

CASE I.—*Tabes Dorsalis in a Woman, aged 48.*

The patient shows the classical features of the disease. [These were demonstrated.] The pathology of tabes is a subject of great interest. It is now known, thanks largely to the work of Dr. Mott, that this disease and general paralysis of the insane are closely allied—some go so far as to say that they are one and the same disease—and that they are caused by some poison, or poisons, which syphilis leaves behind it. Antecedent syphilis, it is said, can be definitely excluded in a certain small percentage of tabetics, but seldom if ever in the case of general paralysis. We may therefore provisionally assume that the two are

closely allied, and that, with the possible occasional exception of tabes, they are always of syphilitic origin. Another disease which may occasionally arise in the same way is progressive muscular atrophy.

Sometimes tabes and general paralysis occur in association, and in this case the former always precedes the latter.

General paralysis carries off more patients in asylums than any other form of insanity. (It may surprise some to learn that phthisis accounts for the largest number of deaths in asylums.) We must assume, therefore, that this is one of the chief ways in which syphilis kills; tabes, being a much more protracted disease, is a less common cause of death. Another way in which syphilis causes death is, I may remark by the way, cancer of the tongue, for, as Mr. Hutchinson tells us, most patients suffering from it have had syphilis.

The question why tabes dorsalis and general paralysis are so much more frequent in men than women is a difficult one. It depends upon some obscure sexual difference of which we know nothing, just as does the greater frequency of alcoholic neuritis in woman than in man. Did we know what this difference is, who knows but that it might furnish some clue to treatment?

CASE II.—*Paralysis of the Anterior Tibial Muscles.*

A domestic servant, aged 27. She has had a very trying place. Seven weeks ago, while going upstairs, she noticed weakness in the left leg, which has continued with very little alteration from that day to this. Examination discloses left foot-drop, complete inability to flex the foot on the leg, *i.e.*, paralysis of the muscles supplied by the anterior tibial nerve; in consequence there is overaction and some shortening of the calf muscles, so that it is not possible, as it is on the other side, to flex the foot beyond a right angle. There is no wasting, the maximum measurement round each calf being exactly the same. [It is always advisable in comparing the girth of the two limbs to take the maximum measurement of each.] The electrical reactions and knee-jerk are normal.

Now foot-drop always makes us think of some lesion in the anterior tibial nerve. Inasmuch as the paralysis came on suddenly, the lesion must be an acute one, and the only possible sudden lesion of the nerve would be traumatic. Did the patient injure the nerve in going upstairs? We may safely exclude any such injury, inasmuch as there is neither

wasting nor altered electrical reactions in the affected muscles. For a similar reason we can put anterior poliomyelitis out of court; the pressure of the knee-jerk is also against this disease. Is it possible that the paralysis is due to an acute lesion, *e.g.*, hæmorrhage in the brain? It is inconceivable that any lesion in the brain could destroy those fibres, or those Rolandic centres which belong to the anterior tibial nerve, and those only. By the method of exclusion we therefore conclude that we have to do with a case of functional paralysis; but whether the functional disability resides in the cortical or spinal level, and why it should pick out that part of the nervous system which belongs to the anterior tibial group of muscles, I cannot say.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

CASES AND COMMENTS FROM THE SURGICAL CLINIC.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

I.—*Case of Bulbar Paralysis.*

AMONGST the most interesting of the cases presented on September 14th was that of a poor woman sent by Dr. Hopkins from the Cleveland Street Sick Asylum with the diagnosis of Bulbar Paralysis. She was very vivacious and quick in the perception of all that was going on, but quite unable to speak. Her only approach to speech was a low grunt produced deep in the throat. She could, however, by movements of her head rapidly convey an answer to most questions. It would have been difficult to exceed by any use of words the emphasis with which she promptly negatived the suggestion that she had been married. Her age was 60. She was exceedingly thin and deeply pock-marked. Her small-pox had occurred at the age of 25, and it was believed that the first symptoms of failure of voice, &c., had begun about four years ago, and that she had been quite unable to speak for nearly a year. Thus the conditions had been slowly aggressive for more than a year. There was nothing in her physiognomy to betray her condition when the face was at rest, excepting that the lower lip drooped a little and that the corners of her mouth were wet. When she endeavoured to speak it was at once observed that her lips took little or no part in the facial movements. She was rather prone to smiles and laughter, but in these the lower part of her face scarcely shared. On examining the mouth it was found to be always very wet with saliva. The tongue lay almost motionless and flaccid. She could not push the tip of it further than the level of the lower gums, and could move it but very little from side to side. On taking the tongue between the fingers and directing her to make an effort to extrude it, it was found that it scarcely made any change. There was a slight approach to firmness in its middle, but very little. The tongue itself was quite clean and somewhat red, and no papillæ,

either filiform or fungiform, could be recognised. It was not exactly beefy, but looked as if it had been soaked. It showed none of the folds or sulci which usually attend atrophy after the division of the lingual, but it was everywhere flabby and soft. Although the woman declared that she could feel in all parts of her mouth, no movements, either voluntary or reflex, were excited by touching the soft palate or pharynx. She allowed the finger to be passed into the throat without resenting it in the least.

As regards concomitant symptoms, the only other evidence of affection of the nervous system was weakness of grip in the left hand. This was quite definite. She would not admit that the hand or any part of it was numb, and she could effect all movements of the digits to a certain extent, but with less vigour than in the other hand. Both hands and both upper extremities were extremely thin, and no very obvious difference could be detected between them excepting that the small muscles of the left hand were evidently yet thinner than those of the right. The pupils were of normal size and acted, for her age, rapidly, and the knee-jerks were normal.

Mr. Hopkins, who sent us the patient, informed us that she had great difficulty in taking food, and could swallow only fluids or very soft substances. The patient graphically illustrated Dr. Hughlings Jackson's epigram upon the diagnosis at sight of this malady: "When you see a patient come into the room with a slate in one hand and a pocket handkerchief in the other, you may say 'bulbar paralysis' at once." The slate is for purposes of conversation, the handkerchief or towel to soak up the constant and profuse dribbling of the saliva.

II.—*Fungating Tumour in Neck: Question of Diagnosis.*

Dr. StClair Thomson was good enough to bring us on October 12th, for diagnosis, a man who had an ulcer on his neck. He was a patient at Golden Square for laryngeal disease, which made him hoarse, and concerning which the laryngoscopic evidence inclined to the diagnosis of syphilis. There was no history of syphilis. The man was 60, and said that although he had had gonorrhœa in early youth he had never had anything else. It was as to the bearing of the ulcer on the neck as an item of evidence, that my opinion was asked.

The history given by the man was that a swelling under the skin of his neck was observed before he became hoarse. This was about four

months ago. The swelling attained the size of a small egg, when it was incised and a "large core" removed.

The conditions of the ulcer were as follows:—Over about the middle of the sterno-mastoid and near its posterior border was a flabby mass of fungating granulations. It was as big as a strawberry, flattened, and everywhere overhung the margins of the skin. It appeared to adhere to the muscle but not to infiltrate it. There was but little thickening at its base, and no proof of enlargement of adjacent glands. The skin, with the exception of the hole through which the fungus grew, was sound. The fungus did not bleed when handled and was not painful.

In discussing the diagnosis, I remarked that syphilitic ulcerations often undermined the adjacent skin, but rarely produced fungus masses, and that they generally were attended by much surrounding inflammation. It was also, on the syphilitic hypothesis, impossible to connect the two lesions. On the supposition that we had some form of malignant growth it might be thought that the throat had supplied infective material to the neck, but then in reply to this there was no proof either of present gland disease or that the original swelling had been in a gland.

Mr. Hichens raised the question whether both lesions might not be tubercular. The man's description of what had been done at the time of the incision fitted well with the evacuation of cheesy tubercle, and his state of health might also be supposed to suggest senile scrofula. He had, however, no definite lung symptoms, nor did he know of any tendency in that direction in his family. One of his sisters had, he believed, had a tumour removed from the abdomen.

(The sequel of this case proved that the diagnosis of cancer was correct. A large malignant growth developed, and tracheotomy became necessary. A drawing has been preserved.)

III.—*Brachioptegia in a Child with History of Fracture of the Humerus during Parturition.*

On Thursday, October 19th, a child, aged 3 years, was brought to us by Dr. Percy Goodman, of Spitalfields, presenting an interesting example of brachioptegia. The child's age and consequent state of alarm made it impossible to test sensation or to determine the condition of any special muscles, nor could we examine the state of the palpebral fissure or test the activity of the iris. It was, however, quite

obvious that the whole of the child's right upper extremity was in a flaccid, helpless condition, and in strong contrast with the opposite hand, the fingers of which were held straight out and were more or less pointed; those of the affected limb were flexed, flabby, a little dusky, and thicker at their tips than elsewhere. All the joints, both larger and smaller, of the limb and digits, were quite loose, and no resistance whatever was made to the attempt to move them. As the child was continually crying and would answer no questions we could not test sensation. It did not appear that any one group of muscles was more completely paralysed than another. There was a history that the humerus had been fractured at the time of birth, and that splints had been used for its treatment. A certain amount of thickening about the middle of the bone gave support to this history. Viewing the case as one in which probably the roots of the brachial plexus had been injured, I examined the clavicle in search of evidence of fracture but found none.

In commenting on this case I adverted to its similarity with a well-known group in which tearing through of the roots of the brachial plexus is the essential lesion. It did not seem probable that the pressure of splints or injury to the trunks of nerves in the upper arm in connection with the fracture was the cause of the paralysis. Had such been the case the lesion would probably have been restricted to certain nerves whereas it seemed probable that the whole extremity was involved.

It was much to be regretted that we could not test the activity of the pupil, for by it the position of the lesion might be determined. If the plexus as a whole were injured at its origin in the spinal cord there would go with it paralysis of the muscular fibres of the iris supplied by the cervical sympathetic. The symptom revealing it would be inability on the part of the pupil to dilate when the eye was shaded. Looked at in a full light the pupils would probably be of the same size, and all that would be observable would be a certain narrowing of the palpebral fissure. On shading the eyes, however, it would be at once noticed that the pupil on the uninjured side would dilate, and that on the affected one remain motionless. In Plate 34 of my *Atlas of Clinical Illustrations* an attempt had been made to exhibit this symptom, and in connection with it an important case of brachioptegia, not dissimilar from the one now before us, will be found described. I suggested that

Dr. Goodman should avail himself of a quiet opportunity when the child was not nervous to investigate this symptom. It would also be of great interest to ascertain whether the child's biceps muscle had escaped. In the case just referred to the man had, some years after his accident, regained full use of his biceps, although all the other muscles of the limb remained paralysed, a condition to be explained by the anatomical fact that the biceps receives its nerve supply from the highest of the nerve roots of the plexus.*

We were told by the mother of the child that so far as she knew the presentation was normal. It was only after some days that it was found out that the infant had a broken arm and that splints were applied.

N.B.—This patient may probably be presented for further observation on a future occasion.

IV.—*Fatty Tumours in Unusual Situations and in Association with Varices.*

Two cases of fatty tumour were brought before us on October 25th. In one case, a man of about 50, the only peculiarity was in its position. It was a large mass as big as two fists placed directly over the right pectoral muscle. It was said to have been not more than a year in growth. It displaced the mammary gland downwards on its lower border, but did not in any way involve it. The other case was one of more interest. A huge mass covered the greater part of the right scapula. It was very soft, and might easily have been supposed to fluctuate, but there could be little or no doubt that it was fatty. Over its margins were a number of tufts of blue dilated veins. Apparently without having any continuous connection with the mass referred to there was a bulging lump in the root of the neck on the right side. It was as large as a small orange, and easily visible. It was very soft, and under pressure of the hand almost disappeared. The external jugular vein was much more conspicuous on this side than on the other, and a large dilated vein crossed the chest horizontally about a hand's breadth below the clavicle. It was a matter of question whether there was any evidence of fatty growth in the armpit or under the pectoral muscle. There could be little doubt that the dilatation of the veins was in connection with the pressure of the fat masses. In commenting on the

* See p. 206, Vol. I.

case I drew attention to the similarity of the tumour in the root of neck to those which are sometimes seen symmetrically in women of middle age, and in association often with nervous symptoms.

In this instance, however, there was no symmetry whatever, the development being wholly confined to the right side. Our patient was a stout powerful seaman, of about 50. He thought that the tumours had made his right arm seem weak. We were indebted to Mr. Johnson Smith, of the Dreadnought Hospital, for the opportunity of seeing the case.

The occurrence of small skin varices in association with fatty tumours is, I believe, not uncommon. I have now under observation a lady who has a fatty tumour on one shoulder, and in whom the skin overlying it is covered with tufts of blue venules.

V.—*Diagnosis between Lichen Planus and an Acute Form of Psoriasis.*

A buxom young woman of 25 showed us an abundant and very conspicuous eruption of florid papules which covered her chest, breasts, arms, body, and face. It was, indeed, general, but less abundant on the legs than elsewhere, and showed a preference for the backs of the fore-arms and hands. Its initial lesion was a lichen papule of a bright red tint but without any umbilicus. Many of the spots were still in this stage, and not larger than shot; others were as large as peas, and many others had coalesced into patches. Everywhere there was slight desquamation. On the face the individual papules were less marked, and a condition of patchy congestion on nose, cheeks, chin, and forehead not unlike some forms of rosaceous acne was the result. We were told that the eruption had all developed within three weeks, and that there had been much itching. Some years ago the girl had had an eruption for a short time "but not like this." The following consultation between Mr. Hichens and myself took place:—

EGO: At any rate, we may agree in this, that it is not syphilitic. Its bright red colour and its uniformity forbid such a suspicion, and so does its preference for the backs of the forearms and hands.

MR. HICHENS: I agree in that. I do not see that you can consider it anything else than psoriasis.

EGO: Did you ever see psoriasis, however acute, come out as a florid acne-like eruption over the whole face?

MR. HICHENS: No ; it is certainly an exceptional case, but if you look at these patches on the backs of the arms they have a scale-crust, and are, it seems to me, just like those of an acute and inflammatory form of psoriasis.

EGO: What do you say to the suggestion of lichen planus ?

MR. HICHENS: I cannot think that it is that. We have no polished papules, and none of them show any trace of umbilication.

EGO: But if you will look here at this large area between the mamnæ where the spots have coalesced, the skin is becoming polished, and it has no scale accumulation. I do not of course say that I think it a typical lichen planus, but it may perhaps be nearer that than psoriasis.

MR. HICHENS: I cannot, looking at the backs of these forearms, forego my opinion that the case will develop into one of common psoriasis, at the same time fully admitting that it has very exceptional features.

My concluding remarks were much as follows:—You have heard, Gentlemen, the little difference of opinion between Mr. Hichens and myself and the question which it will suggest is, Can the diagnosis be settled? Yes, it can, but not by the further appeal to authority in the present stage. We must watch the development of the malady. If it is psoriasis it will persist in spite of treatment, or at any rate it will not be completely cured; if it be lichen planus it will get quite well, and leave the skin as free as ever it was. This difference in tendency is one of the most important features of distinction between the two. If lichen planus persisted for a lifetime, as psoriasis usually does, we might declare it only a variety of psoriasis, but it does not. In almost all cases, and to some extent irrespective of treatment, it gets well—absolutely well—and the patient usually remains free for some years. At the end of a long interval—five, six, or even 10 years—another attack may occur, and from that again there will be a perfect recovery. We all know how different it is with psoriasis. If you do not use the appropriate remedies it usually persists indefinitely and even tends to get worse, and if in some you do effect a cure it relapses almost as soon as you leave off treatment. Thus in the present case the verdict will be given by time. If in the course of six months this girl is quite free, I shall claim the malady as having been lichen planus. I believe that lichen planus and psoriasis are allied, but they are very far from being

identical. We must not construct arbitrary definitions based upon the observation of external features, and then expect all our cases to fit with them. We must be prepared on all sides for overlapping and for deviations from type, and one such is, I think, the case which has been before us.

At this stage Dr. B——, who had brought the patient, interposed with a question as to treatment.

I should, I remarked, give the girl a twelfth of a grain of tartar emetic three times a day, and increase to an eighth or more after a week or two. As arsenic is a specific for psoriasis, so I hold tartar emetic to be for lichen planus. But you must not expect immediate results. This eruption always develops up to its height in spite of remedies, and it is only when it has done so that you can hasten its disappearance. As to local remedies, you may use anything you like of a soothing character. It is a constitutional affair, as shown by its general and symmetrical distribution, and although in later stages topical medication may help, I do not think that it will do anything for you in the present one. You will find that the antimony will soon abate the irritation.

VI.—*Family Gout almost wholly without Rheumatic Complications ; Symmetry ; Anchylosis of Several Joints.*

An important case in illustration of the clinical history of gout was the subject of demonstration on Thursday, November 2nd. The patient, a short, red-haired man of 40, walked badly, having both his ankle joints ankylosed. He had white tophi symmetrically placed on the back of the last joint of both middle fingers, and a single very small tophus in the antihelix of his right ear. Several of his finger joints were ankylosed in straight positions, but he was remarkably free from distortions and other evidences of arthritis. None of his joints were thickened, nor were there any *nodi digitorum* on them. His history was that he had had gout in various joints and severely, ever since the age of 20, and that his father had suffered still more than himself, and “all his relatives more or less.” He had been by vocation a carpenter, as was also his father, and like his father he had continued, in spite of the gout, to drink beer all his life—“Not the black beers, you know, but light ales !” Excepting his attacks of gout he had enjoyed good health. He had never suffered from rheumatism, and had never had either

sciatica or lumbago, nor had he ever heard either of these maladies mentioned in connection with any of his relatives.

I took occasion to point out that the case was a good type-example of one form of family gout, in which the gout tendency exists almost without any complication with the phenomena of rheumatism. It was of much interest to note the tendency to symmetry in the case. Both ankle-joints were ankylosed, and they were the only large joints which showed evidence of disease. So immovable were his feet that it might be suspected that the adjacent tarsal joints were involved as well as the ankles themselves. The os calcis did not move in the least in either foot. When the ankle alone is stiffened there is often so much compensatory motion permitted at the adjacent joints that the disability is to a large extent remedied, and a careless examination might easily overlook the condition.

In illustration of ankylosis as a consequence of true gout I mentioned several cases in which I had myself watched the attack from beginning to end. The ankle and the wrist were, I remarked, the joints most usually so affected, and very severe and prolonged arthritis, with great swelling and much pain, usually lasted for several months. All attempts to employ movement of the joint were out of the question, and when at the end of a three or four months' attack the swelling passed away the joint was found quite stiff. In the end all swelling disappeared completely, and the joint was left quite normal in contour, but absolutely stiff. To attempt to restore motion in such joints as the wrist and ankle was, in my experience, a quite hopeless task.

In not a few of these cases of anchylosing gout there is, if the patient be a man, a history of urethral attacks simulating gonorrhœa, or it may be gonorrhœal rheumatism. They belong, however, to gout rather than to rheumatism, and to gout derived from inheritance rather than that acquired by dietetic habits. In women with this inheritance there is a terrible form of anchylosing arthritis which may cripple many joints.

As a rule a tendency to rheumatism is the basis upon which by dietetic indiscretions the proclivity to gout is built. In exceptional cases, however, the latter is met with almost alone, and it is very instructive in such to carefully study the phenomena. Recurring, severe and very painful but transitory attacks of arthritis, now of one joint and now of another, are the main feature. These

attacks may lead to ankylosis, and when they do so there is an end to the liability so far as that joint is concerned. As a rule, however, no stiffening and but little deformity results. In the present case single severe attacks in the ankles had stiffened them both, whilst repeated ones in the great toes had left them loose and, excepting some grating on movement, in a normal state. The tendency to the formation of "chalk-stones" might be very little. In the present there was not the slightest evidence of such tendency excepting on two fingers, and there they were but small, although very definite.

VII.—*Rheumatic Arthritis with Loose Joints and Displacements.*

An interesting case in contrast with the one just narrated was sent to us by Dr. Josiah Oldfield on the 30th. A woman, aged 60, who in girlhood had been two months in St. Bartholomew's Hospital for rheumatic fever, was now the subject of chronic rheumatic arthritis with loose joints. The symmetry was remarkably exact. The last phalanx of both little fingers was displaced forwards and towards the thumb. At the two proximal joints of both thumbs the distal bone was displaced backwards on its fellow, while at the terminal one the displacement was forwards. The dislocations, although conspicuous, and causing some shortening, were incomplete, and in every instance the bone could by pressure be easily restored to its place, only to slip out again as soon as the muscles were called into action. There was no pain. In the feet the great toes were displaced so as to be almost at right angles with the axis of the foot. None of the affected joints were much enlarged, and there was an absence of osteophytic growths.

I remarked upon the case that it afforded a remarkable example of loose ligaments as a result of past inflammation, and I said that we might guess that it was in part congenital. The woman, on hearing my remarks, confirmed my suggestion by volunteering the statement that an uncle of hers had loose joints, and could displace his thumbs at will, and that when she was a child she used to try to do it herself. I pointed out that the joint between the trapezium and the first bone of the thumb was one very often affected in rheumatic gout, especially in those who used their hands much.

A question was asked as to whether I did not think that the ends of the bones had become smaller and more rounded. To this I replied

that there did not appear any evidence of material change. When restored to position the outline of the joints was normal; there was no grating in movement.

The case was remarkable for the omission of the more usual changes of osteo-arthritis, that is of the outgrowths of bone at the margins of the articular cartilages ("Heberden's nodes"). On the borders of the femoral condyles low lips could easily be felt, but none of the smaller joints were affected by growths of this kind.

The patient knew of no history of true gout in her family. She had herself suffered only the single attack of rheumatic fever which has been mentioned, but she had through life been liable to rheumatic pains.

OTOLOGICAL CASES.

BY DR. DUNDAS GRANT.

Acquired Syphilitic Nerve Deafness.

W. M., formerly in the Navy, afterwards a bricklayer, was referred to Dr. Dundas Grant, by his colleague, Dr. Outterson Wood, at the West End Hospital for Nervous Diseases, on November 15th. He complained of extreme deafness, which had lasted for 12 months, and had come on gradually, but had recently increased with great rapidity. There had been no cerebral disturbance, and only very indefinite vertigo. On examination the membranes were seen to be slightly opaque, but on the whole fairly normal. The watch was not heard on contact. The tuning fork on the vertex was heard rather louder in the left ear, and Rinne's test on both sides was negative. There was, therefore, evidence of nerve deafness, combined with an obstructive condition; the disease affecting the parts common to the middle and internal ear, and in all probability of the nature of periostitic thickening of the outer wall of the capsule of the labyrinth, involving the cochlear and the stapedio-vestibular articulation.

On examination, whispered voice was not heard at all, and even shouted words were hardly audible by either ear. On further investigation it was found that two years previously he had suffered from sore throat, with a rash of some sort, and loss of hair. Fourteen months afterwards he suffered from iritis, of which evidence still

remains. There was no evidence of involvement of other cranial nerves, or, indeed, of any other part of the nervous system.

As there seemed no doubt that the case was of syphilitic origin, the patient was ordered increasing doses of iodide of potassium, and a solution of the perchloride of mercury after each meal, and a pill containing a quarter grain of pilocarpin. In view of a slight improvement produced by inflation through the Eustachian catheter, this instrument has been used once a week.

No real improvement has been effected with regard to the hearing, but he has unconsciously acquired the art of lip-reading, so that he thinks that he can hear better than he did, while at the same time his general nervous tone has improved. This case differs from the most typical form of acquired syphilitic nerve deafness as regards the slowness of its development. The characteristic mode of onset is usually an extremely rapid one, complete deafness being frequently known to occur in from a few hours to a couple of days. In such cases there is probably a rapid effusion into the labyrinth, but in the present one the description corresponds with that given by Pritchard and Cheatele of the form which they consider to be of specific periostitic origin.

Unilateral Deafness of Specific Origin.

J. K., aged 41, came under Dr. Grant's care on June 22nd, 1899, on account of deafness in the left ear. On examination he was found to be almost completely deaf in the left ear, the watch was not heard even when in contact, the tuning fork, by bone conduction, was scarcely heard at all, and when placed on the vertex it was heard entirely in the good ear. There was therefore extreme nerve deafness on the left side. The left side of the face was almost completely paralysed, as was also the left half of the palate and the left vocal cord. He had obviously a lesion involving the facial, the auditory, and the spinal accessory nerve simultaneously.

A history of acquired syphilis was elicited, and there seemed little doubt that the combination of nervous conditions was due to a syphilitic lesion, either in the medulla or external to it, at the point of exit of the nerve mentioned.

The electrical reaction of the auditory nerve was found to be well marked on the right side, but wanting totally on the left, at least in such strength of current as the patient could bear without extreme discomfort.

GIANTISM OF POSSIBLY ACROMEGALIC CHARACTER.

(*Report, with Comments by Woods Hutchinson, M.D.*)

A CASE of most unusual character was, by the kindness of Dr. Macnamara, brought to the surgical clinic in November. This was an Egyptian giant, Hassan Ali by name, alleged to be 7 feet 11 inches in height. He gave his age as 23, and stated that his father was over 6 feet 6 inches in height, and that he had a sister who was over 6 feet tall. Other than this his history, both personal and family, was of no special interest. He has been unusually tall as long as he can remember, and always enjoyed good health.

Although, like nearly all these prodigies whose occupation consists in exhibiting themselves in public, he declined to allow any measurements to be taken, he looked so enormously tall as to render one ready to accept his alleged height as no exaggeration. By careful watching of the level reached by his head upon the pillar of a doorway, and also the point at which his fez touched an electric bracket, two "elevations" were obtained which on measurement yielded 85 inches and 88 inches respectively; so that his height was probably a few inches over 7 feet. This corresponds to the usual deduction necessary from exhibitors' statements of height, viz., from 6 to 9 inches.

At first sight there appears to be no suggestion of any acromegalic element, as both hands, feet, and jaws, though very large, are in fair proportion to his stature. His cranium, however, is distinctly small in proportion to the rest of his body, being but little, if at all, above the average size. Upon determining the position of his hip beneath his loose robes it is found to be extremely high, reaching the level of the shoulder of an ordinary man. This shows his trunk to be short and his legs enormously long, the latter constituting fully three-fifths of his height. So that as, in acromegaly beginning in early life, not merely the hands and feet but *the entire limb* enlarges, we have here a condition of affairs which runs parallel at least with acromegaly, viz., a short or average-sized trunk and small head, with the jaws, arms, and legs of a giant.

This is the usual distribution of the overgrowth in all giants, as measurements made upon several skeletons and bodies have shown that, roughly speaking, two-thirds of their excess of height above the

normal consists in length of leg. And the same region is found to be the site of nearly the same proportion of the shortening in dwarfs. So that the overgrowth in both acromegaly and giantism is really in the same regions, considered in relation to the central nerve-axis.

Moreover, in the skulls of 11 giants and giantesses which have so far been examined, a hugely enlarged pituitary-fossa was found in nine, and in the three recent *post mortems* the pituitary body was correspondingly hypertrophied. Cunningham, after a careful study of the skeleton of the Dublin "Irish Giant," comes to the conclusion that he was acromegalic, and he is inclined to regard the celebrated skeleton, secured by John Hunter and now in the Hunterian Museum of the College of Surgeons, as also of the same type.

But it may be objected that acromegaly is a disease with fatal tendencies, while giantism is merely an overgrowth. As a matter of record giantism may be the more rapidly fatal condition of the two. Very few giants live to be 30 and most die under 22; the average age at death of six giants collected by Dana was 21 years, and as giants seldom begin to "overgrow" before their seventh year this gives an average duration to the disease of about 15 years, while acromegaly may last anywhere from 10 to 30 years.

The typical giant, outside of the legends, is a weak-minded, feeble-bodied, shuffling, splay-footed individual, easily fatigued, and dying at last of a mere coryza or fall in the street. Indeed, the conviction is steadily gaining ground that giantism and acromegaly are manifestations of one and the same pituitary dyscrasia, one beginning before puberty the other after.

Hassan Ali appears in good health and carries his great height well, but his gait is shuffling, his movements lack vigour, he has a slight dorsal kyphosis, and his hand-grip is flabby and weak. The only structural abnormality to be discovered is a large tumour at the front of the neck just below the larynx, probably a congenital cyst. The form of his hands is not in the least acromegalic in type, for they are long and almost slender, but it must be remembered that the "spade-shaped" thickening of the hand does not occur so long as the growth lines of the epiphyses are open. It is only after these are firmly ossified that the overgrowth expends itself, so to speak, in thickening the fingers instead of lengthening them. His face is more characteristic, being long and "horse-like," with rather prominent teeth.

The marked "family likeness" existing between acromegalic patients has been commented upon. That between giants is equally striking. I have been fortunate enough to discover and examine six giants and giantesses, and to secure the photographs and physicians' reports of two more. Five out of the eight might have been members of the same family. Six out of the eight I believe to be acromegalic, and in two of these the diagnosis has been since confirmed by the discovery of a huge pituitary body and expanded frontal sinuses *post mortem*.

EXPEDIENTS FOR PROCURING SLEEP.

SIR WILLIAM BROADBENT'S valuable clinical lecture* on insomnia has elicited much interest in the subject. We are asked, amongst other things, whether there is any scientific term for the tendency to sleep too much, the opposite to insomnia. Another correspondent suggests that tea and coffee, and of course belladonna, should constitute a group of anti-soporifics, since the most characteristic of the effects which they have in common is their power of inducing wakefulness. Another asks whether it is not probable that the insomnia which we hear so much in the present day is largely caused by the dietetic use of tea and coffee. He adds that he is sure that Sir William has not himself suffered, or he would not be incredulous as to the possible influence of tea taken in the afternoon in causing a bad night.

We agree with the last of our correspondents in thinking that it is a matter of importance for all who habitually suffer from sleeplessness to eschew tea and coffee absolutely, and betake themselves to the pre-Shakespearian regime of beer or wine at all suitable meals. We may remind him, however, that insomnia was not wholly unknown even in those days.

Amongst the questions which we heard put to Sir William before he left the theatre was one as to his knowledge of relative sleep-producing powers of different wines. The interlocutor stated, as his personal experience, that port wine kept him awake, whilst claret produced a strong tendency to sleep. It would be interesting if some of our readers would communicate their experience on this matter.

Almost everyone has his own expedient of the psychical class for inducing sleep; the counting a flock of sheep, the perusal of a sermon, the strenuous attempt to keep the eyes wide open are among the most common, and several others were alluded to by the lecturer. A valued contributor sends us, however, a new one, which is too good to be omitted. He says that when sleepless he always begins to place the English kings in order from the Confessor forwards; this done, he places them in their proper centuries, and determines who was reigning at the end of each century, and if by a rare chance he should keep awake to accomplish all this he then proceeds to their contemporaries. The plan he suggests has this to recommend it in preference to the sheep-counting and similar meaningless expedients—that if it fails to send him to sleep it at any rate recapitulates his history.

* Our readers will find the lecture on this subject, which was given in the Polyclinic last week, reported in full in the *Lancet* for January 27th.

OUR STANDING COMMITTEES OF INVESTIGATION.

A DEPARTMENT of our work from which we hope for much good result is that of our Investigation Committees. Of these, four have been appointed, but it is part of our scheme that from time to time others should be arranged to undertake such subjects as it may be deemed desirable to bring under collective observation. These committees will be permanent ones, or will be dissolved only when the work proposed may appear to have been accomplished. The four with which we commence are the following. The members of them have in each instance the power to add to their number, and the members thus added, if willing to give personal work, need not necessarily be members of the College :—

On Leprosy. (Its Prevalence, Etiology, and Treatment.)

Sir Joseph Fayrer.
Sir William Kynsey.
Dr. Phineas Abraham.

Mr. Oswald Baker.
Dr. Radcliffe Crocker (Chairman).
The Librarian and Curators.

On Yaws. (Its Localities, Nature, and especially its Relation to Syphilis.)

Sir William Kynsey.
Mr. James Cantlie.
Dr. Patrick Manson.

Dr. Nicholls.
The Librarian and Curators.

On Diseases Peculiar to certain Climates and on Geographical Pathology in General.

Sir William Kynsey (Chairman).
Sir Hermann Weber.
Mr. James Cantlie.
Mr. W. H. Crosse.
Dr. Alfred Haviland.

Dr. Hillier (Secretary).
Dr. Parkes Weber.
Dr. Theodore Williams.
The Librarian and Curators.

On Tuberculosis. (In all its various Bearings, but with especial reference to its External Forms.)

Sir William Broadbent.
Dr. Burton Fanning.
Dr. George Heron (Chairman).
Dr. Hillier.

Mr. Malcolm Morris.
Dr. Rufenacht Walters.
Dr. C. Theodore Williams.
The Librarian and Curators.

These sub-committees will report to the Library and Museum Committee, but it is not proposed that much should be attempted in the way of formal reports. Their vocation will chiefly lie in the attempt to procure accurate information, to sift and diffuse it in public discussion, and to place it on accessible record. Endeavours will be made to procure for the Library special collections of books and pamphlets, and even of manuscript reports, bearing upon the topics named, and for the Museum pictorial illustrations and models of specimens. These will be from time to time classified and described in our Journal. Most of the meetings of the Committees will probably be made open to all members of the College, and in this way we shall hope not only to secure more general interest in the subjects, but also to obtain special assistance from medical men residing abroad who may be visiting London. It is from the latter class especially that we desire to obtain information, at first hand, regarding climatic and endemic diseases not met with in England. The Committees will not only welcome at their meetings all of this class who may incline to assist them, but will (on approval by the Council) appoint as corresponding members those residing abroad who may be able to supply manuscript reports. It is needless to add that the Librarian and Curators will at all times thankfully acknowledge donations of books, pamphlets, or drawings bearing upon the subjects under investigation. Special arrangements will be made for the deposit of manuscript information, which will be duly catalogued and made accessible under proper conditions to all members. Since our sub-committees will be, as already stated, permanent, it is hoped that as years go on the College will accumulate a large amount of original and very valuable information on the subjects named. It aims to enlist the co-operation of all.

COMMITTEE OF INVESTIGATION ON CLIMATE, &c.

AN open meeting of this Committee will be held on Wednesday, February 21st, when the consideration of the Climate and Diseases of South Africa will be entered on. Dr. Alfred Hillier will introduce the subject, and discussion will be invited.

COMMITTEE OF INVESTIGATION ON TUBERCULOSIS.

THE first meeting of this Committee was held at the College on Thursday, January 11th. Dr. Heron was elected Chairman, and the Medical Superintendent was requested *pro tem.* to act as Secretary. After some discussion as to the scope of work to be undertaken, it was decided to commence by the collection of facts in reference to the external forms of tuberculosis, more especially the affections of the skin. It was agreed that the Committee should meet again on Wednesday, January 24th, and should invite the attendance of all subscribers to the College who may incline to be present. On that occasion it was proposed to take under consideration

THE VARIOUS FORMS OF LUPUS IN THEIR RELATION TO TUBERCULOSIS.

It will be assumed that the name Lupus in modern use always implies the belief that the morbid process so named is in direct connection with the presence in some form of the tubercle bacillus. The following questions and statements are submitted for consideration :—

1. Are the differences in the several recognised forms of lupus to be explained by reference to differences in the particular structure in the skin which is implicated, *e.g.*, the perivascular spaces in lupus erythematosus, the glands in lupus sebaceus, and the corium in lupus vulgaris ?

2. It being granted that lupus erythematosus usually spreads with bilateral symmetry, and that lupus vulgaris scarcely ever does so, what is the explanation ? Is it that lupus erythematosus almost always begins on the nose, and thus naturally spreads equally on both sides ?

3. Is it a matter of general experience that lupus erythematosus in its more characteristic forms—that is excluding lupus sebaceus—always begins on the nose ?

4. Is lupus erythematosus almost always limited in its spreading to the head, upper extremities, chest, and shoulders ?

5. Is lupus erythematosus a disease of which the duration is limited, and which tends to die out of itself after a certain lapse of years ?

6. Is it a fact of general experience that lupus erythematosus is usually associated with tuberculosis in near relatives, and not infrequently with other manifestations of it in the patient ?

7. Is it a fact of general experience that those who suffer from lupus vulgaris very rarely show other manifestations of scrofula, and that they scarcely ever die of pulmonary phthisis? Is it probable that foci of cutaneous tuberculosis exercise a protective influence as regards the lungs and viscera?

8. How are we to explain the spread of lupus vulgaris to various and distant parts of the surface in cases of multiple lupus? It is believed that in these cases the multiplicity is always developed within a few months of the advent of the disease, and that old-standing patches of lupus seldom or never show any tendency to infect distant parts, although they usually continue to spread at their borders through the greater part of the patient's lifetime. Is it probable that the contagion in these cases of rapidly-developed multiplicity is wholly external, and may it be by the agency of insects, or by the patient's nails?

9. Is it probable that the initiation of lupus is always by external contagion, or may it result from mechanical injury to tissues already, in a latent form, containing the tubercle bacillus?

10. What is the nature of the relation between lupus and chilblains?

11. What inference may we draw from the facts which have been established as to lupus necrogenicus? It is assumed that this malady is always due to scratches or pricks received in dissections or from the bones of animals (by cooks; rare). Is it probable that tubercular infection is always effected, or does the injury call into activity germs previously latent in the tissues?

12. May the facts as to the recurrence of lupus in parts which have for many years (20 or 30) appeared quite sound be held to prove that it is possible for the tubercle bacillus to assume a resting or latent condition?

13. May the quiescence of single patches of lupus vulgaris or of lupus necrogenicus during long periods of time be held to prove the possibility just referred to?

14. What is the amount and value of the evidence upon which we base our belief that the tubercle bacillus is present:—1st, in lupus vulgaris; 2nd, in lupus erythematosus; 3rd, in lupus necrogenicus?

A meeting of the Committee to consider the above was held on January 24th, and was adjourned to Wednesday, February 21st, at 5.15.

MUSEUM NOTES.

AMONGST the most interesting of the drawings exhibited in the valuable collection which was got together at the Edinburgh meeting of the British Medical Association in 1898 was one sent by Dr. McCall Anderson, of Glasgow. It represents the body and thighs of a woman on which was developed a large area of blue black growth having a mammilated surface. By Dr. Anderson's kind permission a copy has been made for our Museum, and the following particulars of the case have been furnished by him. At first it was called "*purpura verrucosa*" or "*purpura hypertrophica*," but subsequently the diagnosis was sarcoma :—

"The patient was a woman 66 years of age, who had formerly been in service, whose family history was good, and who had previously enjoyed excellent health. Four months previous to my seeing her, as the result, it was supposed, of poor fare, she began to complain of pain and swelling of the right foot, shortly after which slightly elevated livid spots, about the size of pin-heads, made their appearance on the thigh. These rapidly increased in number and in size until many of them became as large and as elevated as beans, especially on the inner and posterior aspects of the thigh. In these situations the surface of the patches, which were blackish, gradually assumed a distinctly warty appearance and feeling. At this time, too, the whole limb became thicker, so that its diameter was about a half greater than that of the left. This increase was, in the foot, principally the result of œdema; but in the leg and thigh it was mainly, if not entirely, due to induration of the cellular tissue. When I saw the patient this induration was not limited to the limb, but implicated likewise the right side of the abdominal parietes and the right breast, which was firm, round, and plump, while the left was flabby, and about one-third the size. The left thigh was at this time affected similarly to the right, but to a much slighter extent. The legs were quite free of eruption. She complained of neither pain, itching, nor heat, but on placing the hand upon the eruption, especially upon the warty part, it felt much warmer than the healthy skin. The temperature was 1 degree higher than on the healthy skin.

"The right limb felt numb and weak, and she was confined to bed owing to the uneasiness experienced in sitting. She was thin, but not more so than many people of her age, her appetite was bad, and her bowels exceedingly costive, as the result probably of the confinement in bed. Otherwise she appeared well, and was very cheery. She gradually sank, three months after I first saw her, and seven months from the commencement of the disease, suppuration having occurred shortly before death at those parts which were in contact with the bed."

A LARGE and classified collection of drawings illustrating lupus is at present displayed in Rooms 3 and 4. It is in connection with the subjects under debate in the Tuberculosis Committee. The Curators

will be thankful for the loan of other drawings. We shall catalogue them in our next number.

Bielt's Bands—Ichthyosis Herpetiformis.

THE Museum will contain a valuable series of portraits, mostly photographs, illustrating these curious bands. Various names have been given to them, but the principal facts are now well recognised.

They are almost always observed in early infancy, and are no doubt connected with developmental peculiarities. They often occur in strict



limitation to one side of the body or one limb, and when bilateral are scarcely ever symmetrical in all parts, and they seldom or never affect more than one member of the same family. The drawings show that the nature of the morbid changes in the skin may vary from a mere stain to a keratosis of considerable density, or to papillary growths of some height, or even to the production of pendulous folds of thickened and discoloured skin (dermatolysis).

Several of these photographs are from the collection of St. Louis Hospital in Paris, and others have been presented by various donors. The following may be specially mentioned :—

A photograph given to Mr. Hutchinson by Dr. Cæsar Boeck, of Christiania, with the diagnosis, "*Hyperkeratosis folliculo-poralis striata.*" The patient was a woman, aged 24 ; no relations suffered from skin disease. It was reported to have begun in childhood, but had probably been congenital. The arrangement is more nearly in bilateral symmetry than is usual.



In contrast with Professor Boeck's is another photograph given to Mr. Hutchinson by Professor Bäümle of Freiburg, which shows a wholly unilateral arrangement of these streaks and patches :—

It is that of a man of 46, and the condition had been present from birth. The portrait shows a broad vertical streak running up the forehead from root of nose with others to right of it ; on the right side of the nose itself there are patches, and large ones occupying almost the whole of the cheek. The chin is free, and so is the malar region and the nose tip. Dr. Bäümle states that there was present a line of small papules running down the hard palate from before backwards close to right of middle line.

NOTES ON THE SURGERY OF THE WAR.

A COMMUNICATION from Sir William McCormac to the *Lancet* confirms in most definite manner what I had written last month, as to the comparative insignificance of wounds by modern bullets treated by modern surgery. He tells us that wounds of the lung occasion but slight symptoms, and that bones are sometimes perforated without splintering, and that fractures of this kind, although compound, if promptly closed with antiseptic dressing, do quite well.

I have noted with much interest that some cases of bullet perforation of the abdomen, in which, in all probability, important viscera were wounded, have yet done perfectly well, and have escaped peritonitis. From the character of the surgeons who have gone out we may confidently expect some important contributions to our knowledge of the surgery of wounds. Amongst the questions as yet open to debate, is as to whether as a general rule, in wounds of the abdomen, it is well to search for the bullet or the wounded viscus or to let things alone. It will, of course, be said that each case must be decided on its own merits, but whilst admitting this to some extent, I may yet hint that I believe that the surgeon who does the fewest abdominal operations will save the largest percentage of patients. I have published a case of this kind, which many years ago made a great impression on my own mind. I was called, as consulting surgeon to the Poplar Hospital to see a ship's captain who had been shot in the abdomen a few days before. The bullet was still in, the belly was distended, and the man in a most critical condition. He was on the operating table when I got to the hospital, and my colleagues were prepared to open the abdomen. I dissuaded them, being under a strong impression that the man would not survive to get through the operation. Nothing was done, and he left the hospital well. It is perfectly true that in some of these cases an operation may save life, but it is equally true that in others, and perhaps a yet larger number, it may greatly add to the danger. Unfortunately it is often impossible to discriminate the cases. Carefully collected series of cases will be of great value.

I became so much interested in the proposal made last month as to the construction of a "Heart-protector," that I have been induced to try to devise one. The shield which I got made consisted of a quarter-

inch plate of aluminium (which is exceedingly tough and not brittle), lined outside and inside by sole leather unattached. Mr. Holland, of New Bond Street, who kindly undertook to try it for me at his rifle range, expressed the opinion that at short distances bullets would go through it "like so much butter," but he admitted that it might be serviceable in the case of those which had lost some of their velocity. The shield, which is curved to fit the left side of the chest, weighs about two pounds. The result of trials has not been encouraging, and I mention the matter chiefly for the guidance of those who may be thinking of similar contrivances. I feel sure that something of the kind ought to succeed.

The well-informed military correspondent of the *Daily News* has been going a little beyond his last in recommending drugs for ailments in the camp. He has advised his readers to take with them "*Fowler's* sedative solution of opium," and has told them vaguely that ipecachuana (without the slightest hint as to dose) is the specific for dysentery. It might perhaps be wise, when he next writes on these matters, to submit his lucubrations to a medical expert, or at any rate to consult his druggist. Even the latter might tell him that Fowler's solution contains arsenic and not opium, and give him a tip that he might, in *Dover's powder*, find an excellent combination of his two favourite drugs, which would be invaluable for the purposes suggested.

CORRESPONDENCE AND ANSWERS.

WE agree with "Subscriber" that it would be very advantageous to have short discussions after the clinical lectures. A few questions judiciously put would often be very helpful, both to lecturer and audience. We hope that in future arrangements will be made to allow of this.

* * *

H. P.—The title of the book about which Dr. P. asks is *La Maladie de Carrion*. It is published by Carré and Naud, of Paris, and is well illustrated. Carrion is the name of a young Peruvian physician who sacrificed his life by making an experimental inoculation on himself. He succeeded in proving that the fever known as "Fievre de l'Oroya" was the first stage of the malady characterised by a frambæsiæ eruption under the name of Verrugas.

* * *

Erratum.—In our review last month of Dr. Monro's interesting work on *Raynaud's Disease*, we regret to notice that we misspelt the author's name. It is Monro, not Munro.

COLLEGE NOTES.

At a late meeting of Council two resolutions were adopted, which will add very considerably to the convenience and comfort of the members. The first provides for the installation at the College of the telephone, and the second for the accommodation of bicycles. These facilities will bring many more attending the Polyclinic within easy access of their work, should they be wanted during their attendance on classes or lectures.

* * *

ANNUAL Subscriptions became due on January 1st. It will be a convenience to the College and an obligation to the Treasurer if members will kindly remit their dues early.

* * *

At one of his mid-December clinics, Sir William Broadbent brought forward a most interesting case of locomotor ataxia. The man also suffered from double aortic disease, and had recently developed tremor and other symptoms suggestive of the approach of general paralysis. There was an undoubted history of specific taint, acquired many years ago. He was a sailor by occupation, and had not been too careful in his habits, but he had never suffered from rheumatic fever. This patient will probably return to the Polyclinic for further observation from time to time, and it will be interesting to observe whether he ultimately glides into general paralysis. The case is peculiarly interesting and instructive, as bringing together in one person two, if not three, important pathological conditions known to own syphilis as their direct ancestor.

* * *

FROM the recent pass list of the University of London we observe that three ladies passed in the first, and nine in the second division. Women graduates are now so numerous that it may, ere long, become necessary for our Council to seriously consider whether or not they shall be eligible for admission to the membership of the Polyclinic. The great stumbling block to such a concession would probably be the necessity it would entail of conducting "mixed" classes. Should the time ever arrive when women present themselves in such numbers as to make up classes of themselves this difficulty would at once be solved.

A HIGHLY successful short course of lectures on "The Ocular Muscles" was given during the last half of December by Dr. Ernest Maddox, of Bournemouth. The lecturer treated his subject with much skill, and handled it so attractively that he was closely followed by a large and attentive class, every member of which regretted that the course comprised so small a number of demonstrations as four. This fault may be remedied on a future occasion should it seem desirable. We are glad to know that Dr. Maddox will probably give another course on the same subject during the month of June.

* * *

SOME notably distinguished additions have been made to our roll of office bearers. The Right Hon. Sir John Lubbock, M.P., F.R.S., LL.D., &c., upon whom Her Majesty has recently conferred the dignity of a peerage, has done us the honour of becoming a vice-patron of our College, and our list of vice-presidents is augmented by the accession of Sir John Watt Reid, K.C.B., LL.D., M.D., Honorary Physician to Her Majesty the Queen, and late Director-General of the Medical Department of the Royal Navy, Sir James Crichton-Browne, LL.D., M.D., and Sir William O. Priestley, M.P., LL.D., M.D., &c.

* * *

THE clinical lectures during February are arranged for as follows:—

Feb. 9th.—Professor McCall Anderson, of Glasgow. Subject: "On the Uses of Tuberculin in the Diagnosis and Treatment of Disease."

Feb. 21st and 28th.—Dr. Patrick Manson. Subject: "Malaria Parasites and Malarial Disease."

The lectures in January given by Sir Wm. Broadbent and Dr. Savage were attended with gratifying success, and attracted representative audiences.

* * *

WE doubt whether it is generally understood by the members of the Polyclinic that any one of their number may, subject to the approval of the Council and on terms to be ascertained from the Medical Superintendent, acquire the use of one of the lecture rooms for the purpose of giving one or more clinical demonstrations. It must constantly happen to men engaged in practice, whether special or general, that rare and interesting cases present themselves which they

have full opportunity of studying in detail, and which would be of immense interest and utility if presented to the general body of the members in the form of a practical demonstration, given by the man who has watched the case throughout. It is true that provision is already made for discussion upon such cases at the ordinary afternoon consultations of the College, but many men prefer to demonstrate their own cases, and it goes without saying that the man who has had the most extensive opportunities for repeated observation should be, if he is observant and careful, the best qualified to bring out the salient features or striking anomalies of a case. It is highly desirable that the opportunities offered by the College for this class of work should be made use of. A good case of unusual character, skilfully demonstrated, will not only attract a large audience, but will provoke criticism, which must tend to unravel diagnostic difficulties and add to the general sum of our clinical knowledge.

* * *

IN view of the near approach of the annual meeting it is opportune to remind subscribers that in order to obtain the right of voting at annual meetings and to be eligible for election to the Council they must become *members* of the College. The only responsibility involved is a possible liability for a sum of ten shillings in the event of the College becoming a financial defaulter. Most subscribers will probably consider such a risk remote enough to be ludicrous. In order to attain the membership subscribers must submit their names for the approval of the Council. This formality is obviously necessary as a safeguard, but, except under unlikely circumstances, it may be looked upon purely as a formality. We would urge subscribers to avail themselves of their right to become members, and so increase their personal interest and influence in the affairs of the College. Those who are desirous of taking this step should hand their names to the Medical Superintendent within this month, so that they may be approved by the Council at its March sitting, in time to exercise the franchise at this year's general meetings.

* * *

THE attention of members is called to the fact that our registered address is "POLYCLINIC." The use of this word will prove a considerable economy to those who have occasion to communicate with the College by wire.

DIARY FOR THE MONTH.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m. Committees at 5.15 p.m.

FEBRUARY.

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|----|-----------|------|---|--|
| 1 | Thursday | | Cons. (Surg., &c.). | Mr. Hutchinson. |
| 2 | Friday | | Cons. (Ophth.). | Mr. Treacher Collins. |
| 5 | Monday | .... | Cons. (Dermat.). | Mr. Malcolm Morris. |
| 6 | Tuesday | .... | Cons. (Med.). | Dr. Williams. Council Meeting. |
| 7 | Wednesday | .... | Cons. (Med.). | Dr. Guthrie Rankin. 5.15, Sub-committee on Climate (open). |
| 8 | Thursday | .... | Cons. (Surg.). | Mr. Hutchinson. |
| 9 | Friday | .... | Clinical Lecture : "The Uses of Tuberculin in the Treatment and Diagnosis of Disease." Prof. McCall Anderson. | |
| 12 | Monday | .... | Cons. (Dermat.). | Mr. Malcolm Morris. |
| 13 | Tuesday | .... | Cons. (Med.). | Dr. Williams. Library Committee. |
| 14 | Wednesday | .... | Cons. (Med.). | Dr. J. F. Payne. |
| 15 | Thursday | .... | Cons. (Surg.). | Mr. Hutchinson. |
| 16 | Friday | .... | Cons. (Ear and Throat). | Dr. Dundas Grant. |
| 19 | Monday | .... | Cons. (Dermat.). | Mr. Malcolm Morris. |
| 20 | Tuesday | .... | Cons. (Med.). | Dr. Williams. Lectures Committee. |
| 21 | Wednesday | .... | Meeting of Tuberculosis Committee (open), 5.15. | |
| 22 | Thursday | .... | Cons. (Surg., &c.). | Mr. Hutchinson. |
| 23 | Friday | .... | Cons. (Nose and Throat). | Dr. StClair Thomson. |
| 26 | Monday | .... | Cons. (Dermat.). | Mr. Malcolm Morris. |
| 27 | Tuesday | | Cons. (Med.). | Dr. Williams. Finance Committee. |
| 28 | Wednesday | | Clinical Lecture. Dr. Manson. | |

MARCH.

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|---|-----------|------|-------------------------|--------------------|
| 1 | Thursday | | Cons. (Surg.). | Mr. Hutchinson. |
| 2 | Friday | | Cons. (Ophth.). | Mr. Holmes Spicer. |
| 5 | Monday | | Cons. (Dermat.). | Dr. Galloway. |
| 6 | Tuesday | .... | Cons. (Med.). | Sir Wm. Broadbent. |
| 7 | Wednesday | .... | Cons. (Surg.). | Mr. James Berry. |
| 8 | Thursday | .... | Cons. (Surg.). | Mr. Hutchinson. |
| 9 | Friday | .... | Cons. (Ear and Throat). | Mr. R. Lake. |

Tuberculosis 5.3

Climate 21st

Leprosy April 4

DIARY FOR THE MONTH.

APPOINTMENTS AT OTHER INSTITUTIONS, SOCIETIES, &c.

FEBRUARY.

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|----|-----------|------|--|
| 1 | Thursday | | Royal Society, 4.30. Röntgen Society, 8. |
| 2 | Friday | | |
| | | | |
| 5 | Monday | | |
| 6 | Tuesday | | Pathological Society (Laboratory Meeting), University College, 8.30. |
| 7 | Wednesday | .... | Obstetrical Society, 20, Hanover Square, 8. |
| 8 | Thursday | .... | Royal Society, 4.30. |
| 9 | Friday | .... | Clinical Society, 20, Hanover Square, 8.30. Gynecological Society, 8.30. |
| | | | |
| 12 | Monday | .... | Mr. Treacher Collins's Lecture at Royal College of Surgeons. Medical Society, 8.30. |
| 13 | Tuesday | .... | Medico-Chirurgical Society, 20, Hanover Square, 8.30. |
| 14 | Wednesday | .... | Mr. Treacher Collins's Lecture at Royal College of Surgeons. Dermatological Society, 8.30. |
| 15 | Thursday | .... |  |
| 16 | Friday | .... | Epidemiological Society, 8.30. |
| | | | |
| 19 | Monday | .... |  |
| 20 | Tuesday | .... | Pathological Society, 8.30. |
| 21 | Wednesday | .... | Royal Microscopical Society, 8. |
| 22 | Thursday | .... |  |
| 23 | Friday | .... | Clinical Society, 8.30. |
| | | | |
| 26 | Monday | .... | Medical Society, 8.30. |
| 27 | Tuesday | | Medico-Chirurgical Society, 8.30. |
| 28 | Wednesday | | Dermatological Society of Great Britain, 5. |

MARCH.

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|---|-----------|------|---|
| 1 | Thursday | | Röntgen Society, 8. |
| 2 | Friday | | |
| | | | |
| 5 | Monday | | Medical Society, Lettsomian Lecture, 9. |
| 6 | Tuesday | .... | Pathological Society, 8.30. |
| 7 | Wednesday | .... |  |
| 8 | Thursday | .... | Ophthalmological Society, 8.30. |
| 9 | Friday | .... | Clinical Society, 8.30. |

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. II., No. 3.—MARCH, 1900.

MEDICAL CHARITY.

THE fundamental axiom that the profession of medicine exists for the benefit of mankind and not mankind for that of the professors of medicine will be disputed by no one. It will follow that the relief, so far as is possible, of physical suffering from disease or injury ought to be accomplished, for all classes, as promptly, as completely, and as cheaply as circumstances may make practicable. None but the charlatan would feel other than disgust at the idea of availing himself of the sufferings or anxieties of a fellow man as a means of extracting money from him. None, not even the charlatan, but would, did circumstances permit, gladly remove those anxieties and relieve those sufferings without thought of fee or reward. These propositions are simple truisms, but when we come to the task of endeavouring to make practical application of them to the needs of our social life we have to face problems of much intricacy. Medical knowledge is not to be obtained without much expenditure both of time and money by those who seek to qualify themselves for its application.

“I believe every man has found in physicians great liberality and dignity of sentiment, and willingness to exert a lucrative art where there is no hope of lucre.”

More than a century has passed since these words were written by an astute observer of human nature, and they are, it is to be hoped,

as true now as they were then. It is not to be denied, however, that since Dr. Johnson's day changes in opinion have come as to the special directions which medical benevolence ought to take. We no longer applaud indiscriminate charity in this, or in any, department of the social scheme, and we hold strongly that it is the duty of all practitioners of our art to consider carefully in what manner their conduct may affect the legitimate interests of others before they yield to the impulses of sympathy which their hearts may prompt. A physician who should be willing to see patients gratuitously or for inadequate fees would no longer receive the indiscriminate praise which a former age would have accorded him. Not only is it recognised that such conduct may be very unfair to others, but our political economists assure us that it may be very prejudicial to the self-reliance of the recipient. Yet most certainly no one wishes that the field of medical charity should be restricted by arbitrary laws. No one wishes that illness and accidents involving bodily pain and disability and the risk of death should be made the means by which their sufferers should be forced to part with money which they can ill spare. Everyone turns with pain from the thought that when the father of a family is disabled and his earnings stopped, he and his family should be impoverished by the demands made for the means of cure. Illness and suffering must ever excite sympathy in the human breast, and nothing that the political economist can urge will ever convince anyone that it is the same thing to offer a man who is sick gratuitous aid as it is to bestow goods or money on a person who is healthy. In this regard the profession of medicine stands quite apart from all the pursuits of trade. It is the high privilege of those engaged in it that they are often in the position of being able to afford invaluable aid to others without any direct pecuniary loss to themselves. None of these considerations should, however, make us careless as to the manner in which medical relief is offered gratuitously to those who ought not to be required to pay for it. Without holding back in the least from the assertion that the number is very large to whom such relief may be most suitably afforded, we must still acknowledge that the determination as to who they are, and as to how it should be given, is a subject worthy of very careful consideration.

Three points respecting medical aid will be admitted by all: it should be prompt; it should be the best possible; and it should cost its recipient as little as the expense of its production will permit. It

is needless to say anything as to value of promptitude. Good advice given at the onset may often be, it is obvious, worth ten or a hundred-fold what its value might be at a later stage. It is not only that time has been wasted, very often the occasion has passed also, and it may be quite impossible to regain what has been lost.

Those who are familiar with the organisation of the Polyclinic will not need to be told that the statements just made are preliminary to the assertion that it claims to stand paramount amongst medical institutions in the efficiency with which it designs to deal with the problem of medical aid to those who are not rich. Its central idea is the higher efficiency of the profession as a whole, but more especially of those engaged in general practice. It has been alleged by some of our critics that we are opening a new field for the abuse of medical benevolence, and by others that our scheme of operations is one likely to prejudice the interests of Consultants. Some of those who allege the latter have even gone so far as to say that we aim at making consultants unnecessary. We are not concerned to deny for one moment that if the consummation suggested as a possibility be attained by perfecting the skill and knowledge of family practitioners, we shall be quite willing to let consultants as a class take care of themselves. No one, however, who gives the subject a moment's thought can doubt that, however high the general standard of knowledge and experience may be raised, it will always be possible for men of superior endowments and larger experience to command such a position in the ranks of the profession as will ensure them the resort of those who can afford their fees. No one who keeps his eyes open can have failed to observe that the improved education of our day has tended somewhat to modify the relative positions of different branches in the profession. The same agencies are still at work, and their effect will be still more evident in the future. It will be a glory to the Polyclinic to take some share in the result. The gain will be very great to the public, and to the profession as a whole it will be no less whatever.

Nor, as regards the opportunities for gratuitous consultation at the Polyclinic, do we believe that private consultants need bear us the slightest grudge. Apart from the fact that no patients are admitted, excepting on medical introduction as being suitable objects, the mere fact that all consultations take place in public will serve to deter almost all who are not so. If, in the future, any tendency to abuse in this

direction should be observed, it will not be difficult to check it. That none has as yet occurred may be most confidently asserted.

Usefulness as a medical charity giving skilled advice in difficult cases gratuitously, constitutes, however, but a very small part of that which we believe that we are accomplishing. Our main object is, by affording to those engaged in practice opportunities for acquiring increase of knowledge, to achieve potential results far surpassing in value, to the public, those directly obtained in our own consultation theatres. We hope in this way to make available, not only in the homes of the poor but in those of all classes, a kind of experience which, under the older arrangements, was not possible of attainment. In proportion as this can be done shall we have succeeded in meeting the claims of human sympathy, and of obviating objections on the part of the economist. We shall have put it in the power of many who have hitherto resorted to hospitals, to obtain similar benefits at their own homes, and without even the slightest sacrifice of self-reliance. Above all—since it is evident that the early stages of disease must almost invariably come under the treatment of the family practitioner—we shall, by securing that such early treatment is of the best, have effected much in reducing the number of cases which lapse into chronic or incurable stages. Such are our aims, and such our hopes.

J. H.

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It is a most interesting coincidence that in the recently published reports upon malaria of both Koch in Java and Celli in the Roman Campagna, special stress is laid upon the frequency of the occurrence of malaria in children.

Koch, indeed, insists that the extent of the prevalence of the disease in children, as tested by the presence of the parasite in their blood, is the only reliable test of its prevalence in a community, inasmuch as many adults who have survived the attacks of the disease in childhood have acquired thereby a more or less complete immunity. So that the number of cases occurring in the adults of a community is not in any way a fair test of the frequency and virulence of malarial infection in that locality. In the latter part of Koch's work he relied upon this test—the examination of children's blood—almost entirely, making several thousand examinations in all, and the results were found to

run parallel with the abundance of *Anopheles* and occurrence of suitable breeding-pools in a remarkable manner.

The parasites were often found in the blood where no clear history of malaria could be obtained; in some villages in as high as 20 per cent. of the children examined being so infected, and the younger the children the higher was this percentage. The proportion affected of those examined under 1 year of age was nearly double that of the entire series, showing, in connection with the absence of the disease in the adults of the village, that there was a process of immunity by survival going on, and that malaria is to be regarded as a most important factor in the notoriously high infant death-rate of the tropics.

Moreover, as Koch points out, these findings throw a flood of light upon the well-known fearful odds against the survival of European children growing up in the tropics, as, having been born of non-immune parents, they are at a serious disadvantage and contract the disease in a much severer form. The same fact has been noted in the malarious regions of the United States, where the fatality of malaria in the children of recently arrived settlers is sometimes appalling.

The new test is also most valuable in discriminating between indigenous and imported malaria in any given neighbourhood. There are two districts in Java which Koch specially visited on account of the reported presence of malaria, and yet freedom from mosquitos. In both places the cases of malaria were found to be confined to adults, who had had opportunities of contracting it in the plains below, and the examination of the blood of a large number of children failed to discover a single parasite. So that the connection between the mosquito and malaria would now almost seem to amount to a mathematical demonstration.

The increased control over the prevention of the disease given by these observations is enormous, as every case in childhood, either prevented by proper protection from night exposure or promptly recognised and checked by quinine, means one less source of further infection of mosquitos and conveyance to other human subjects. Breaking the chain of infection at this point, combined with the destruction of the larval *Anopheles* in its breeding-pools, or the drainage of these latter, ought to go far to stamp out this chief enemy of mankind in the tropics.

W. H.

If it be the fact that in all forms of Lupus the period of activity and of local spreading by contagion is limited by years, or even by months, and that after a certain stage the disease manifests but little powers of aggression, it becomes of great interest to inquire whether the same applies in any degree to other forms of tuberculosis. The opinion is probably gaining ground that many persons who are threatened with phthisis, and in whom the tubercle bacillus was certainly present in the lung tissue, recover. In other words, the bacillus ceases to be active and shows but little tendency either to extension in the part first affected or to the infection of others. The same fact is observed even in certain well-marked cases of phthisis in which the local processes have made some advance. Now these are precisely the facts which it is suggested find their parallel in the history of lupus, and dermatology may possibly here afford valuable evidence in support of the conclusions of the general physician. The surgeon also may take his share, and may derive encouragement in the treatment of cases of surgical scrofula, even in severe and multiple forms, by recognising that in the natural history of the bacillus there is a law which limits the duration of its activity, and further, that those who have once recovered from what may be called an acute attack of scrofula often enjoy through subsequent life good health without any tendency to relapse.

J. H.

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OUR Committee of Investigation as to the Climate and the Geography of Disease is desirous to appeal to the profession generally for the gift of books, pamphlets, papers, extracts, &c., in relation to its several subjects. Many communications of much value in these directions are printed locally, never obtain any wide distribution, and are now not obtainable through booksellers. The Polyclinic is, moreover, not wealthy, and could not afford to expend money in their purchase. It wishes, however, to form a large and classified library of reference on the subject. As a sort of basis, an interleaved edition of Hirsch's Handbook and similarly treated Gazetteers will be placed on our shelves. In these any additional items of information as regards the subjects or places mentioned may be inscribed. With them it is desired to place as much other documentary material as can be collected. Many of our readers probably possess books and

pamphlets of this kind which they are not likely to put to any particular use. They are precisely the kind of literature which becomes cumbersome in a private library, and is really useful only when carefully classified, arranged, and catalogued on the shelves of a public institution.

On the Diseases of South Africa the Committee especially desires to state that it will be glad to receive any papers, either old or new, which bear upon the subject. It would like to have several copies of the *South African Medical Journal*; Reports from the Robbin Island Hospital, and from any other hospitals and medical institutions, are also wished for. Authors sending their original papers will add to the obligation if they send two copies. Local maps and local guides will also be gratefully received. They should be addressed to the Librarian at the Polyclinic.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON A CASE OF PERNICIOUS ANÆMIA.

BY W. M. ORD, M.D., F.R.C.P.

GENTLEMEN,—I will commence by reading to you some notes of this case :—

C. L., aged 45 years, baker, first came under observation January 10th, 1899.

The patient's father died of pneumonia and his mother of "old age." The rest of the family are living and healthy. The patient is a temperate man and appears never to have suffered from syphilis or malarial fever. With the exception of two slight attacks of dysentery and an attack of "asthma" he has always enjoyed good health. The patient dates his illness from the early part of 1888. He was at this time in Port Elizabeth, South Africa. His first symptoms were transient attacks of faintness of short duration, occurring at frequent intervals, and obliging him to lie down. He noticed, too, that he was becoming pale. He returned to England in February, 1898, improving somewhat on the voyage home, but speedily relapsing again. He, however, struggled on with his work until the latter part of that year and then had to give up.

When admitted to St. Thomas's, in January, 1899, he was obviously suffering from extreme anæmia, but showed no signs of cardiac dilatation, nor had he any swelling of the legs. A few rhonchi were present in the lungs, and some brown patches, the remains of hæmorrhages, were found in the right retina. The blood count on admission was :—

Chromocytes	...	...	...	...	960,937 per cubic mm.
Hæmoglobin	...	...	...	...	Between 10 and 20 per cent.

The treatment adopted was the administration of liq. arsenicalis, commencing with 4 minims t.d., and gradually increasing to double that amount. Slight epistaxis occurred whilst under observation, and it was also noticed that the legs swelled slightly when he got up. The condition of the blood gradually improved and 44 days after the count given above, the result was :—

Chromocytes	...	...	...	...	2,788,185 per cubic mm.
Hæmoglobin	...	...	...	...	70 per cent.

Once or twice, soon after admission, the temperature in the evening was febrile, but with these exceptions it remained normal. The arsenical treatment induced a little soreness of the eyes and some relaxation of the bowels. The urine was normal and was not high coloured.

The patient was discharged on March 8th, 1899.

For three months he continued regularly at work, but after that he began to relapse into his former state. He became breathless and languid, subject to palpitations and occasional swelling of the ankles, but he had no further epistaxis, no failure of sight, and no hæmorrhages.

Re-admitted October 27th, 1899.

Had a plump, well-nourished appearance. His weight was 8 stone 5 lbs. (when admitted before, 8 stone 11 lbs.). The skin was of a pale yellow tint, and the face showed a pink malar flush. The features were heavy and expressionless, the lips somewhat thick, and the forehead smooth. The fingers thick and clumsy, the skin of the hands dry and harsh. Speech slow and deliberate but distinct. In short the general aspect was thought suggestive of myxœdema. The respiratory movements were free. The percussion note over the lungs fully resonant. Vocal fremitus and vocal resonance equal on the two sides. Numerous variously pitched rhonchi were heard on auscultation, as on the occasion of his previous admission. The area of cardiac dulness was of normal extent and a faint impulse was felt in the fifth intercostal space, half an inch internal to the nipple line. The heart sounds were but feebly heard at the impulse, and over the pulmonary area a faint, blowing, systolic murmur was present. The liver dulness was of normal extent; neither liver nor spleen were palpable, and the abdomen appeared normal in every respect. The ankles were slightly œdematous. Some thickening and deformity at the lower third of the left tibia marked the site of an old fracture. The nervous system appeared normal. Knee-jerks present and equal. The pulse was 80 and the vessel relaxed. Urine, specific gravity 1015, acid. No albumen. No sugar. Colour amber. Blood examination, October 30th :—

Chromocytes	....	....	....	1,404,000 per cubic mm.
Leucocytes	....	....	....	3,600 „
Hæmoglobin	....	....	....	35 per cent.
Colour index	....	....	....	{ Proportion of hæmoglobin } { Proportion of chromocytes } 1 : .8.

The proportions of the different white cells were :—

Finely granular oxyphils	....	32.5 per cent. (normal 70–72 per cent.).
Lymphocytes	....	61.3 „ „ 22–24 „
Eosinophil cells....	....	5.8 „ „ 2–4 „

Cover glass preparations showed considerable variation in the shape and size of the red cells, many being very large; seven small nucleated red corpuscles were seen in three cover glasses. Only one doubtful megaloblast was present. Many red cells were undergoing degeneration and polychromatophilic change. Blood platelets were in considerable excess of normal.

On account of the supposed appearance of myxœdema the patient was for a week put on thyroid treatment (thyroid tabloids, gr. 2 b.d.). The blood count at the end of this time showing no improvement, arsenic was substituted, and this he is still taking. The temperature is still occasionally febrile.

[For the above notes I am again indebted to Dr. Box.]

I think there can be no doubt that the man has anæmia, and I should say that probably that is the most important part of his illness. I think

we may accept the statement that he has no sign of disease in the lung, that he has only a little pulmonary systolic murmur which would go with weakness, that there is no obvious visceral disease, and that his urine contains neither albumen nor sugar. Clearly, I think, we may best start here with the examination of the primary and most important symptom, the anæmia. We have, therefore, to think of the various kinds of anæmia. Pernicious anæmia or, as it was originally called, "idiopathic," by Addison, is one. As regards the nomenclature, it is rather curious that Addison began by declining to state the cause, in using the term "idiopathic." We have in the term now chiefly used given up the idea of indicating ætiology, and merely note the pernicious effect. I think that is rather a retrogression in nomenclature.

Of course, there are anæmiæ that belong to ages and individuals and to various obvious morbid states. As regards ages there is, of course, the typical chlorotic anæmia of the young woman. Pernicious anæmia is one which belongs to adult age, or generally later and middle age, and is more common in men than in women. Next the anæmias that are associated with bodily conditions of an obviously enfeebled character, and there is also the anæmia which follows hæmorrhages and wasting discharges. This patient has had some hæmorrhage, but it has not been constant or large enough to produce anæmia. Of course, at all periods of life, long-continued hæmorrhages of any kind will produce anæmia, but an anæmia which is neither that of the pernicious type or the well-nourished anæmia of chlorosis. We have the anæmia which results from wasting diseases, we see it in phthisis and in all sorts of chronic affections which interfere with nutrition. Those are related, I should say, for the most part to the anæmia which follows loss of blood; they depend upon the existence of causes which interfere with nutrition or involve the expenditure or loss of more nutrient material than is replaced.

Allied to these are anæmiæ that we see in connection with cancer. Perhaps they are more notable in cancer of the stomach and duodenum than in others; certainly there is a distinct anæmia which goes with cancer, but it is again accompanied by a different condition of face and skin. We have there the condition that we recognise as the cachectic one, where there is an expression of face full of anxiety, drawn muscles, and not only pallor but a dusky coloration, in fact, most marked pigmentation. Then we have the singularly transparent, pigmentless

anæmia associated with certain diseases of the spleen, particularly with the splenic enlargement of leucocythæmia, associated, not determined, by hæmorrhage, but, of course, apt to be very much aggravated by the hæmorrhage so frequently present in that disease. There are many other kinds of anæmia, but it would take too long to enumerate them. There is an anæmia which belongs to Bright's disease, particularly noticeable in the large pale kidney, and we must not forget that anæmia with fulness of the skin, but without pigmentation and without particular tint, and, of course, associated with marked albuminuria and other evidence of advanced renal disease.

Then there is an anæmia which is very like that at first sight, namely, the anæmia of myxœdema. I do not think I should have ventured to think of the existence of myxœdema in the case before us. It has been discussed, but the man has not in any way the physiognomy of it. Possibly his mode of speech may have attracted notice and led the observer's mind in that direction. In myxœdema we have swollen eyelids and big projections around the eyelids, and in that disease we have nothing like the yellow quality presented by the patient, but there is a pallor, and a much more marked swelling of the skin. In the present case I should hardly admit that there is any obvious swelling. Then again, in myxœdema there is the limited flush, thickening of the alæ nasi, thickening of the lips and ears, and thickening of the tongue. Our patient has also a good crop of hair; so that I think we can certainly exclude myxœdema. I think there is nothing to make it include any other kind of anæmia which may be dependent upon obvious existing disease, hæmorrhages, cancer, or palpable mischiefs in the body, and we must put the case under the head of idiopathic or pernicious anæmia. One important reason is that the examination of the blood was very much in favour of this. There is no increase of leucocytes but rather a diminution, and another point is that while the hæmoglobin is diminished in a given quantity of blood it is increased in a given corpuscle. There are changes in the red corpuscles in pernicious anæmia.

The first thing that one notices before going to more minute observations is that the red blood corpuscles are distinctly enlarged and far less sharply defined in their margins than normal. The next is that they are irregular in shape, often oval, and in consequence of that, and more or less interference with the central depression, they do not form

perfect rouleaux. Thirdly, they are obviously softer, for when they meet one another under the cover glass they squeeze one another out of shape very easily. In the little current that runs between masses of corpuscles, the corpuscles on the side of the current are drawn out into long, fine little tails, and they are distinctly more vivid in colour, being a little yellowish. I always think that they look a little more yellow in colour than the red blood corpuscle of health.

I was so much struck by this some years ago that I took specimens of the blood from two cases of pernicious anæmia and compared them with two specimens of blood from healthy people in the spectroscope. I could not find any difference whatever. I fully expected to find some different spectrum, but I did not trust myself, and I took them down to my friend, Sir William Huggins, who also said there was no change, so that the yellowish appearance cannot be a reality, but is only some effect of refraction. In some cases of this disease the white corpuscles are increased, but we have not to concentrate our attention so much upon them as upon the red. Then we notice here the tendency to faintness and giddiness, and there is certainly in these cases a tendency to hæmorrhage, but we still have not touched the origin, and one can hardly say at present that it is known. Sometimes the spleen is enlarged, sometimes it is smaller than normal. Various accounts of the liver are before us. In some it appears to be enlarged and too firm, in others small. There is no known regular variation of organs. As regards signs of general change, I think it may certainly be recognised that with this disease, rapid fatty degeneration occurs in various organs, particularly the liver, heart, muscles, and spleen.

Then, while we cannot find much regular change in the size of the liver, it is now known that the liver contains an unusual quantity of iron, deposited along the lines of the vessels, the quantity being large enough to be made evident by the use of ferro-cyanide of potassium. Sometimes we can trace the course not only of the blood vessels, but of the biliary ducts in a case of this kind when a solution of ferro-cyanide of potassium is employed. The probability appears to be that the red blood corpuscles have been broken up elsewhere in the body by some degeneration, and that the iron contained in them has made its way into the liver and been deposited there. There is one point in this case which is important and bears upon this. It is most common in an idiopathic or pernicious anæmia to find the urine very

much darker than usual, and it has been shown that the change in colour is due to a form of altered urobilin or colouring matter contained in the urine and originally derived from the liver. In fact, Dr. Hunter proved this, not only by the colour of urobilin, but also that this morbid urobilin had the property of breaking up the blood corpuscles and destroying their identity, except so far as their general identity might be indicated by the persistence of the various reactions. It has been suggested that there is at work here also some other morbid product allied to the ptomaines, but that has to be proved a good deal more clearly than it has been at present.

You will observe that the anæmia here occurs in a man who has been in Africa. A form of anæmia like this is not uncommon in such people and in certain miners and other persons. There are two possible causes: sometimes apparently the poison of malaria destroys the red corpuscles, and there is no doubt that certain parasites have great influence, particularly the *ankylostomum*. I think that this worm does this mostly through producing diarrhœa, but certainly also by some change set up in the system. As you know, the St. Gothard workmen had this disease most severely, and it is also extremely prevalent in South Africa. I may say that the fæces of this patient have been examined, and I shall suggest that such examination be continued for any indication of the presence of parasites, *ankylostomum* or other, and a careful look-out should also be kept for any indications of parasites in the blood.

With regard to treatment in such cases, iron is almost useless. The notes tell us that the man has benefited greatly by the use of arsenic, but he has had relapses. Dr. Stephen Mackenzie drew attention to the great tendency to relapses after apparently successful treatment. Phosphorus and hypophosphites have done good in some hands, and in my opinion a most valuable remedy in a large number of cases is the red marrow of bones. As far as we can make out, the laboratory in the system, which makes the red blood corpuscles either produces them in insufficient quantities or an imperfect condition. We now know that the ends of the bones contain laboratories larger in apparent bulk than the spleen itself. Whether they produce exactly the same kind of blood corpuscles, one does not know, but there can be no doubt that a large amount of blood formation goes on in them. We cannot so well, I think, feed a man on spleen as we can on the red

marrow of bone, and I have tried the latter now in a good many cases with very good result. It may be given either by taking teaspoonfuls of the red marrow from a long bone of the ox ; and I think it is best given fresh with a little salt or in a sandwich, once, twice, or three times a day, according as it is borne. It is also prepared in the form of tabloids, where the marrow is dried and baked. This is not at all a bad form, but not nearly so rapidly effective as the fresh marrow. There are solutions of it in glycerine made, which are used by the mouth or hypodermically. Personally I should prefer the fresh marrow regularly given, and, failing that, the tabloid form would be better. Of course, at present, people use many organs of the body in one way or another, fresh or in extract, not always I think with judgment, not always quite safely, but I think that the use of the red marrow in such a case as we have before us is absolutely philosophical, and I see no reason why arsenic should not be employed at the same time. We must, I think, submit to be called polypharmacists ; you do not always prescribe iron alone, or bark alone, or quinine alone.'

ANGINOSE ATTACKS DUE TO AORTIC INSUFFICIENCY.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

February 6th, 1900.

OUR first patient, a vigorous man of 35, comes with a history of severe attacks of pain in the chest, radiating into the left arm and forearm.

According to him these began abruptly nearly three years ago without any previous illness or premonitory symptom. He is quite sure that he never had rheumatic fever, and declares that he "never knew what illness meant" until these seizures began.

The spasms of pain are very severe, often going to the extent of causing fainting, so that he has to be most careful how he exposes himself in positions where there is risk of a serious fall, and as he is a builders' labourer by occupation this is a most serious matter for him. The attacks, which were only at distant intervals at first, have gradually become more frequent, until now they may occur almost daily, and any unusually severe or sudden exertion, especially in the way of climbing or lifting, will bring one on. A year or so ago he was given tabloids of nitro-glycerine, and has come to rely upon them absolutely, carrying a box of them in his pocket continually, and being afraid to stir abroad without them. One of these, followed by a few minutes rest, will usually completely relieve an attack, and then back he goes to his work, to bring on another one. The poor fellow obstinately persists in his original occupation, as he says he has a family to support, and this is the only means by which he can earn wage enough.

All this directs suspicion to his heart, which on examination is found much hypertrophied with an ill-defined apex beat. There is a loud aortic regurgitant murmur, but the pulse is feeble and soft, though slapping, and there is no visible pulsation in the vessels of the neck.

The condition is evidently an inadequacy of the aortic valve, brought about by severe and long-continued muscular over-strain. This is much more commonly seen in those who work in heated and vitiated air, such

as furnace-men or smiths, than in outdoor labourers; and although a certain amount of compensation has been established there, yet the patient's colour is pallid, his hands are bluish and cold, and the heart-muscle is evidently proving inadequate to the strain put upon it.

Were it not for the evident valvular mischief, the symptoms would point strongly to the possibility of aneurysm, but there are no adequate physical signs of this.

The outlook, of course, is bad, as, like all forms of severe aortic disease, a fatal attack may occur at any moment, especially in view of his laborious occupation, involving the lifting of heavy weights, unloading of wagons, &c. As insurance examiners, we regard cases of aortic mischief as constituting the worst risks of any class of cardiac lesion.

As to the causation of his anginose attacks, the question arises, Are they true angina, and due to a fatty heart-muscle or diseased coronaries, or rather a temporary distress due to vaso-motor spasm or other disturbance of the circulation in the vessels supplying the heart and the cardiac ganglia? The latter seems more probable, as the attacks, although serious and disabling, scarcely produce the agony and dread of approaching death so characteristic of true angina.

In this disease, as Dr. Ord has well remarked in his admirable lecture upon angina in a recent number of *THE POLYCLINIC*, the severity of the attack and unfavourableness of the prognosis are often in inverse ratio to the actual lesions discoverable. In no class of cases should our prognosis be so guarded as in those where no apparent organic cause can be detected, or where the attacks appear to depend upon or be accompanied by a distended stomach, and are ever relieved by the expulsion of gas. These cases may die in the next seizure, even though in other respects apparently pictures of health.

However, in this case the angina is chiefly symptomatic, and his prospects depend mainly upon the progress of his valvular lesion. If this had been due to rheumatism the outlook would be much more favourable, as the lesions at least might remain stationary, unless another attack occurred, but being apparently solely due to prolonged over-strain there are probably degenerative changes in the valve-flaps, which are almost certain to progress steadily, especially if he persists in his present occupation. Could the patient change to light work and take proper rest and care, the process might be arrested, but as he

seems to think that, because nitro-glycerine will always quickly relieve an attack and enable him to go back to work again, this state of affairs can be prolonged indefinitely, and would also unfortunately find it difficult to change his occupation without seriously diminishing his wages, the prospects of an arrest of the disease are extremely poor. This illustrates a great drawback of nitro-glycerine, in that patients get to depending upon it too much and thinking themselves in the process of cure, when only the acuter symptoms are being temporarily relieved.

On the other hand, in the pure anginas the mental effect of the drug is sometimes most soothing and even helpful, and the mere presence of a box of the tabloids in the pocket will give the patients confidence and enable them to go about their work in comfort. In a case recently seen by the lecturer, the patient was still carrying his tabloids, although there had been no attack for a year.

A Case of Double Aortic and Mitral Insufficiency.

Our second case is chiefly of interest on account of the unusual combination of murmurs and lesions present. The condition is one of double cardiac mischief of rheumatic origin in a healthy young married woman of 23. She gives a clear account of several attacks of "rheumatic fever," and of one of chorea when 13 years old. The first rheumatic attack was the most severe, and was followed by shortness of breath on exertion, though her present severe attacks of dyspnoea and palpitation began only nine months ago.

There is a loud aortic regurgitant murmur heard over the lower part of the sternum, and a fainter systolic apex murmur of mitral origin. This is an interesting illustration of how murmurs, even of clearest organic origin, may vary from time to time, as when seen a few days ago the mitral murmur was not only louder than the aortic, but also distinctly double, while to-day it is single and comparatively faint. Last week the case was distinctly a mitral one with aortic complications, to-day the aortic element is strongly predominant. Even the pulse is distinctly aortic in character.

Severe and complicated as the valvular lesions evidently are, the outlook for the future of the case is not unfavourable. As the mischief is of rheumatic origin, and has reached a definite limit, beyond which

there is no further tendency to progress, and the possibilities of compensation at this age of life are excellent, a working adjustment will probably soon be reached with rest, care, and good feeding. Even now, although the pulse shows evident signs of regurgitation, yet the patient's aspect is good, her nutrition is well kept up, and everything is to be hoped from the recuperative powers of youth. The younger the patient the more hopeful the prognosis, and at 15 or 16 years of age there is hope of recovery from, or of compensation, of even most serious valvular lesions, being established.

ON PSEUDO-HYPERTROPHIC PARALYSIS, BERI-BERI, AND OTHER CASES.

BY GUTHRIE RANKIN, M.D.

February 7th, 1900.

GENTLEMEN,—Our first case is a somewhat atypical form of pseudo-hypertrophic paralysis in a boy of 9. As you see, he is fairly well grown, his colour is good, and expression cheerful, but he is quite unable to stand alone, to say nothing of walking, and when partially supported he assumes the characteristic attitude of the myopathy, legs wide apart to increase width of standing base, hips shot forward, head thrown back, producing marked lordotic curvature. When he first came into the hospital three months ago, he was just able to walk with a typical waddling gait, but the paresis has progressed rapidly since then.

The disease has been practically life-long, as the little fellow was backward in learning to walk and the first clear symptoms appeared at 2 years of age, so that he has never walked properly. Other than this his history presents nothing of interest.

There has been no similar disturbance in any member of his immediate family, but a first cousin, on the mother's side (sister's son), died in a very similar condition at the age of 17 years.

The muscles of his arms and shoulders are greatly wasted, as well as paralysed, so that, as you see when I lift him up by the arms, his shoulders pull right up to his ears, as Sir Wm. Gowers has described. I place him upon this blanket on the floor and tell him to stand up, and he "climbs his own legs" in most typical fashion. The atypical feature is that there is no actual enlargement of the muscles of the calves, though I think you will agree with me that, as contrasted with his arms, they are relatively much better developed, and certainly are not at all wasted. The knee-jerks are absent, the electrical responses feeble, the legs mottled, and the feet blue and inclined to be cold.

Erb groups together all these myopathies under the title "Progressive Muscular Dystrophy," and holds that we have to deal with functional disturbance and subsequent structural change in the trophic centres of the cord; the former causing muscular changes only, the

latter associated with coarse anatomical lesions and giving rise to myo-atrophy of the spinal type.

As these myopathies tend to run in families and occur chiefly in young people, there is possibly some congenital defect of the cord underlying them; indeed, such has been discovered in a few cases.

The possibility of Friedreich's disease is suggested, and the highly-extended and arched position of the feet does resemble somewhat the curious deformity of that malady, but there is no affection of the speech, no muscular tremors, no nystagmus, and the general picture of the disease is absent. This case also shows the tendency of myopathy to run in the female line.

Our next case is one of that curious neuritis of toxic origin, *beri-beri*, in a Chinese sailor, Ah Sing, aged 30, who was brought to the Dreadnought Hospital three months ago. He is one of a group of four men who were taken from filthy quarters in the fore-castle of a vessel in the China trade, lying in the Thames, by order of the sanitary authorities, and were all found suffering from this disease. They all had œdema of the legs and back, a band of anæsthesia down the shin, great tenderness of their leg-muscles on pressure, and were quite unable to walk. One of them died within a few days by heart failure, but the other three have made slow recovery, our patient being the most backward case.

He is so much improved that his condition is no longer a strikingly characteristic one, but, as you see, the knee-jerks are absent, he flinches at the lightest pressure upon his leg-muscles, especially his gastrocnemii, and there is great loss of power in both legs and arms. He walks with a shuffling gait, but no longer drags his toes. Still, even in their much modified form, this group of symptoms can only be ascribed to the peripheral neuritis of *beri-beri*.

Dr. Patrick Manson has, I think, practically proved the bacillary origin of the disease, but the precise habitat and distribution of the germ are not yet clear, although it does not seem to get into the blood, and affects the general system only by its toxins produced outside the body and either inhaled or swallowed.

The disease is not directly infectious, and we have never found it to extend to other cases in the hospital. In unsanitary surroundings, however, transmission of the disease does take place, three

and four cases developing one after another in the same house, or ship, as in the present instance. The infection may then linger about for months.

When the toxin of the germ, after attacking the peripheral nerves, reaches the vagus, then death by heart failure may occur, as in one of the present group. I am informed by Sir William Kynsey that, in the East, another result of vagus-poisoning, vomiting, is regarded as a most serious symptom and the precursor of a fatal termination.

Our third case is one of aortic disease, closely simulating aneurism, in a man of 39. The patient is a sailor, has had a hard, rough life, with frequent "sprees" when on shore, and gives a history of syphilis 15 years ago.

About two years ago his attention was first attracted to his heart by attacks of palpitation, and shortly after he noticed marked pulsations in the vessels of his neck, especially on the right side. He went on with his work until he began to spit blood and to have fainting seizures, when he came into the hospital. This was some three months ago, and the attacks were alarmingly frequent, lasting about ten minutes, and accompanied by severe pain in the heart, radiating into the left arm.

There was marked enlargement of the heart, affecting both ventricles, visible throbbing of both carotids—which, indeed, may still be seen as he sits here—and a striking inequality between his radial pulses. This inequality was not only obvious to the finger, but most clearly shown by the sphygmograph.

Great improvement has now occurred under the use of iodide of potassium and nitro-glycerine. The right border of the heart has receded an inch toward the median line, the attacks of angina have ceased, and the patient looks like another man.

There is a to-and-fro murmur present over the aortic area, a water-hammer pulse and capillary pulsation. These, taken with the marked throbbing in the vessels of the neck, point to considerable regurgitation through the aortic orifice. There has been no tracheal tugging, no dulness to the right of the sternum, and no alteration of voice or pupils. There is probably dilatation and loss of elasticity of the aortic walls from degenerative changes, and the difference between the radial pulses may be due to narrowing of the innominate artery from calcareous deposit.

ON CASES OF LYMPHADENOMA (HODGKIN'S DISEASE).

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—We have had before us from time to time a number of cases of the infective form of gland disease which Dr. Hodgkin was the first to describe, and which has since received the name of Lymphadenoma. One of the most marked of these we have just examined,



and I now show you a photograph of the same patient taken three months ago, by which you may estimate the progress which his malady has made. As you have seen, the lad, in spite of his enormous gland

growths, still maintains what he considers a condition of fair health. He is, however, very pale, and admits that on exertion he becomes breathless. He is in a dangerous condition, and we might at any time hear that he had become seriously ill, either with head or chest symptoms or with sudden failure of strength. As yet we have not detected any enlargement of his spleen, although the glands in his neck, armpits, and groins are all much enlarged. He is under Dr. Sequeira's observation, and it is through that gentleman's kindness that we have had



MASTER M. (*From a Photograph.*)

the opportunity of seeing the case, and I feel sure that his zeal for the advancement of clinical knowledge will ensure our having information as to the sequel. The lad's disease has now been two years in progress, and he is 20 years of age.

Not very infrequently, I believe, these cases terminate with head symptoms. This was what happened in the patient whose photograph

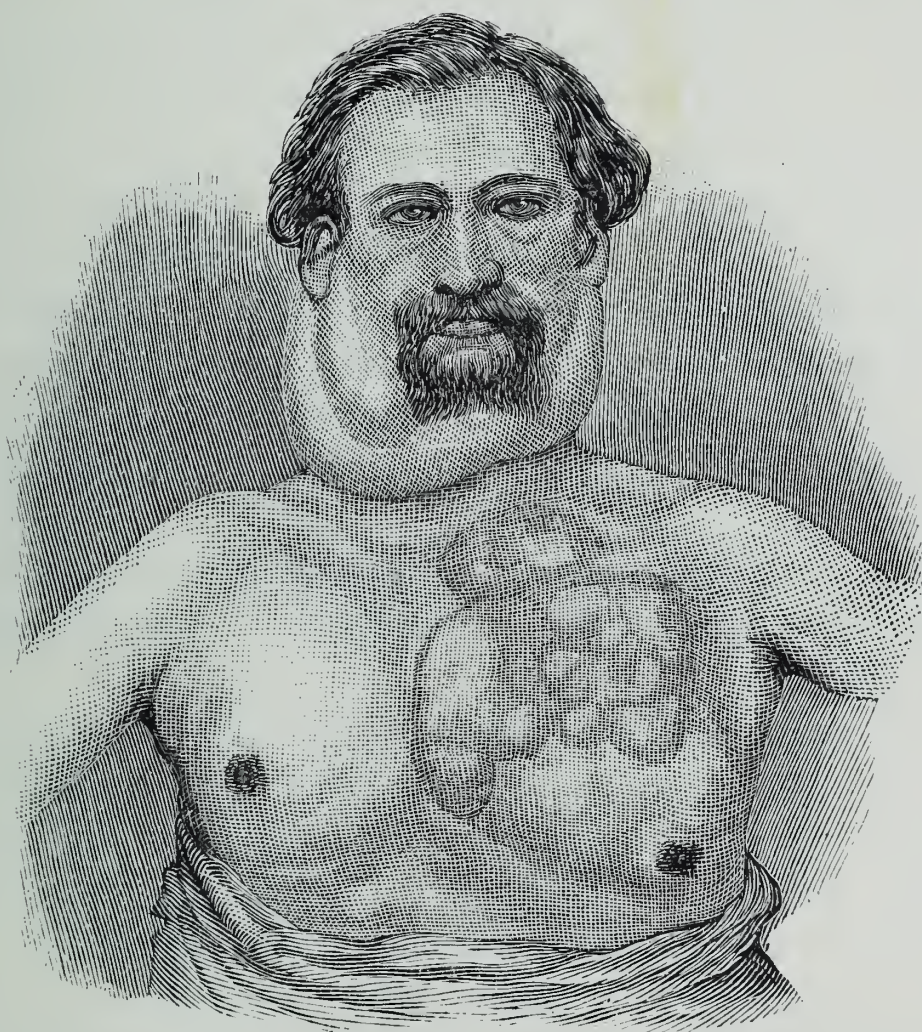
I next show you. It may well pair with that of our present case, for both were young men, and in both the gland masses had attained a very large size before the health failed. I am in a position, unfortunately, to tell you the end as regards this second patient. He had been under my observation several years, and had been much benefited by treatment—the use of arsenic, and repeated sea voyages, &c. Under these measures he had kept up his strength, and the growth of the glands had been restrained. Suddenly one morning, when he called on me, I found that he talked incoherently; I sent him back to his hotel, and told him to go to bed. Severe headache followed, with high temperatures. He passed into coma, and, to shorten the story, within a fortnight I made an autopsy, and found in the meninges many scattered masses of lymphoid tubercular growth, about which inflammation had occurred.

I am also able to state to you the conclusion of another case, though without autopsy. It is that of a man, whom some present may remember to have seen at one of my demonstrations at Park Crescent, before we moved to the Polyclinic.

Amongst the cases which were presented during the autumn of 1897 was that of an old man, named Stiff, who was the subject of lymphadenoma. A portrait was kept, which shows a very large gland mass in the right side of his neck. It was stated to have developed during the last few months, and the patient had during his previous life enjoyed good health. By the kindness of Dr. Stocker, of Forest Gate, under whose care the man was, the following particulars may now be added:—

“After the consultation Stiff got gradually worse. The glands in his neck attained an enormous size, and those in the armpit pressed upon the veins and nerves, so that the limb became greatly swollen and painful. His breathing became difficult, but there was no definite evidence of mediastinal growth. He died suddenly on March 29th, 1898. He had never been confined to bed; he was downstairs when his wife, who was in another room, heard him fall. She found him in collapse, but quite conscious, and he died within an hour, probably from cardiac failure.” Dr. Stocker adds that the skin over the gland masses had become adherent to them and discoloured, and that, had the man lived much longer, ulceration would probably have taken place.

From the rapidity of the progress in this case, the great preponderance on one side only, and from the way in which the gland masses became adherent to the skin and adjacent tissues, we may infer that the growth was closely allied to lympho-sarcoma of a malignant type. Yet in its early stage there was nothing to distinguish it from ordinary forms of lymphadenoma. It began by painless enlargement of glands which were neither adherent to each other nor inflamed, and when he first came to us, although the tumour hung over the clavicle it still did not



Sir Andrew Clark's Patient. (From a Photograph.)

present any of the more ordinary features of malignant disease. Its malignancy was shown by its rapid growth. I show you a portrait of the man, and by its side I place one of a patient many years ago under the care of my colleague, the late Sir Andrew Clark. In this latter case—a typical one of lymphadenoma in its general features—a large infiltrating growth occurred in the subcutaneous cellular tissue of the chest-wall, and thus we had demonstration of the near relationship of the malady to sarcoma.

The mention of these cases, and the comments which I have just made as to their alliance with malignant lympho-sarcoma, leads me to make a few remarks as to the pathology of the malady.

Let me, in approaching this matter, say plainly, as I have often said before, that much needless complexity is introduced into our researches by the habit which clinical observers have of insisting too much on differences. We recognise and describe certain typical forms of disease and then try to insist that these shall each rank as species, and that subsequent observers shall group their cases under one or other of the names which have been invented for them. This method appears to me to be, to a large extent, a mistake. I feel quite sure that we shall not only simplify our expressions and our ideas in relation to disease, but also approach very much nearer to pathological truth, if we decline to conform to it. We must endeavour to get a little behind the scenes of our theatre and to get a glimpse of our actors in undress as men and women, and not attach too much importance to mere costume. This done, we shall probably find that there is more of essential relationship between the villain and the hero than we had supposed when we saw them on the stage.

Now, as to the subject which we have in hand—the infective diseases of the lymphatic glands—there are a number of different names in conventional use.

From time immemorial the terms “struma” and “scrofula” have been in habitual employment in connection with these affections. More recently we have added, in the hope of being more precise, the term “tuberculous disease of glands.” And we have discovered and named the maladies known as “Hodgkin’s disease,” “lymphadenoma,” “lympho-sarcoma,” and some others. These different names are all very useful if we keep them in their proper place, but if we allow them to designate conditions presumed to be wholly and essentially distinct, and which should rank in reference to the nomenclature of pathology much as species do in zoology and botany, then I feel sure that they will cramp our conceptions and lead us into error. We have such things as “species” in some departments of our work—for instance, the specific fevers, but as regards by far the greater part of the field for investigation which lies before us, any such definite conception of a morbid entity is out of the question.

Even with regard to the diseases which are most nearly specific, it

would be well, I think, if we should admit that hybridity is quite possible, and that much with which we have to deal is the result of two or more specific causes working together. It is by forgetting this that many useless discussions as to names and diagnosis originate. "May it not be both?" is a question which the clinical observer should be constantly asking himself. It may seem that the suggestion would open the way to vagueness and, perhaps, to indolence, but that it would often lead us to truth I cannot in the least doubt. Premising, then, that the terms "Hodgkin's disease" and "lymphadenoma" are convertible and are applied to one and the same condition, let us next ask what is the relation of this condition to "scrofula" on the one hand and to "sarcoma" or "malignant growth" on the other. I would suggest that it stands midway between the two, that it is of mixed parentage, and that it partakes of the qualities of both.

In lymphadenoma we recognise a chronic affection of the glandular system, which, beginning locally in some one set of glands and very probably due to a surface lesion, results in slow extension to the whole of the glandular system, and finally to the spleen, of a condition of hypertrophy similar, in greater or less degree in different cases, to malignant growth. It differs from scrofulous disease in that we can but rarely recognise anything definitely of the nature of tubercle, and that there is very little tendency to soften and break down. It differs from malignant growths in that the microscope recognises only the cell elements of gland tissue, and that there is seldom any tendency to the invasion of adjacent parts or to ulceration. Both as regards scrofula and sarcoma, however, there will be found plenty of cases which stand midway, and which do not conform with accuracy to what I have just said.

As regards gout and rheumatism, I have often ventured to use the comparison of the mixing of spirits and water. Our tumbler may contain a great deal of water and very little whisky, or on the other hand the quantity of spirit may be liberal. Let the water represent rheumatism and the whisky gout, and it will not be difficult to realise that between the weakest and the strongest there may be all gradations.

Permit me now to apply the same illustration to the subject before us, and to assume that a patient may inherit a tendency to malignant processes of growth, and that he may at the same time be in the

position of host to the tubercle bacillus. Clearly the conjunction is a possible one, and nothing is more probable than that, when it



Woodcut showing the bunch-of-grape-like arrangement of the Glands in Lymphadenoma. (*From a water-colour drawing in the Author's collection.*)

occurs, the two would modify each other. Thus, then, we arrange all our cases of infective disease of the glandular system according to the degree in which one or other of these two influences may seem to preponderate. We have a lympho-sarcoma at one end and common suppurative scrofulous disease at the other. Between these are endless modifications, and nowhere any abrupt lines of demarcation.

Further, let me assert that it is quite possible for an affection which has had its beginning in one class of causes to change its face and assume not only the features but the character of the other. Thus, then, we make a truce to quarrels about verbal diagnosis and we gain, I think, a clear insight as to possibilities in reference to mutual relationship.

Let us from the beginning hold most definitely that both kinds of disease—and, indeed, almost all kinds attended with anything of the nature of inflammatory hypertrophy—are infective in the individual in whom they originate.

The greater the tendency to suppuration, the nearer the relationship to tuberculosis. The slower and the more quiet the growth and the greater the freedom from inflammatory action, the more closely does the case conform to the type of lymphadenoma. The more rapid the growth and the closer probably is the relationship to "sarcoma," but this name must always be regarded as nothing more than equivalent for tendency to develop in a "malignant" manner.

I show you lastly the beautiful portraits recently published by the New Sydenham Society which will illustrate what I have just said, and by their side I place others taken many years ago from a case of my own.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CONSULTATIONS.

BY WM. M. ORD, M.D., F.R.C.P.

January 30th, 1900.

CASE I.—*Hæmatemesis due to Gastric Ulcer.*

THE salient features in the history of this patient, a man of 53, looking more than his age, are prolonged anæmia extending over some years past, with recurrent attacks of rather severe vomiting of blood. The clots vomited during these seizures have been a mixture of both dark and bright-coloured blood, but the lungs as a possible source of the hæmorrhage may be excluded, as there is little or no admixture with air or frothy matters.

The patient has lived a life of much hardship and exposure, and at one time his food supply was extremely deficient for a prolonged period. His habits have also been irregular, but there is no history of specific disease.

In October last he had an attack of vomiting, with so heavy a loss of blood that he fainted. There has been a little pain and uneasiness just before each hæmorrhage, and some indigestion and vomiting of food between the attacks, but other than this he has been almost free from pain. His heart and lungs reveal nothing abnormal. His history suggests several possibilities as to the causation of the vomiting—carcinoma, cirrhosis of the liver, gastric ulcer, &c., but as there is no sign of tumour to be elicited, and no marked enlargement of the liver to be detected, the consultant is inclined to regard the last of these as the cause of the attacks. The ulcer is probably one of the irregular, superficial type with ragged edges, and due chiefly to the disturbances of nutrition, consequent upon deficient food supply and exposure. The anæmia is to be regarded as a result of this general malnutrition, and a contributory cause of the ulceration, while, of course, it would be increased by the repeated losses of blood.

The stomach is distended with gas, indicating flatulent dyspepsia,

which should be relieved as promptly as possible. The chief indications for treatment are rest, both bodily and gastric, a diet of milk, eggs, and puddings, with abstinence from stimulants ; and Dr. Ord was inclined to avoid the use of drugs, unless an exception be made in the case of iron, in the form of the saccharine carbonate, as least likely to irritate the surface of the ulcer.

CASE II.—*Tubercular Peritonitis.*

The patient, a young man of 30, gives a history of failure of nutrition, with chronic gastritis and abdominal pain, extending over the past six months. His bowels have been most irregular, diarrhœa alternating with constipation. There have also been morning cough, with some expectoration, night temperatures, and occasional sweats. His colour is poor, lips bluish and dusky, while the fingers are distinctly clubbed, and across several of his nails runs a white line of opacity, such as usually indicates a serious illness, disturbing the general nutrition.

As he lies upon the table his abdomen is evidently prominent and distended, causing an appearance of depression at the lower end of the sternum, and there is on palpation a marked "sullen," doughy resistance all over the surface of the belly. There is no localised firmness suggestive of tumour, although on deep pressure a small area of rigidity can be detected in the right groin. The liver is not enlarged, and there are no spots of tenderness. After the abdominal muscles had relaxed somewhat, scattered "plates" of resistance could be made out, suggestive of thickenings in the peritoneum. There is no very marked tympanitis, and only a trace of fluid in both flanks.

Upon turning to the chest, distinct dulness of the left apex is readily made out, together with friction sounds, dry rales, and bronchial breathing. Taking the abdominal findings, the chest signs, and the history together, the consultant had little hesitation in pronouncing the case one of tubercular peritonitis.

Fortunately the prognosis in these cases is much more favourable than it was at one time regarded. Many cases recovered, even without surgical interference, and, as a last resort, laparotomy and washing out of the peritoneal sac is a hopeful and often most effective means of permanent relief. Dr. Ord advised further trial of rest, good feeding, and tonics, with biniodide of mercury, to promote absorption of exudate, before operation was resorted to.

GENERAL SURGERY.

BY RICHARD LAKE, F.R.C.S.

CASE I.—*Cystic Tumour of the Parotid Gland.*

J. T., aged 32, a barman, came under observation three months ago complaining of a swelling in front of his right ear. A firm rounded tumour about the size of a walnut was found to be present and has changed but little since. The growth is well defined and very elastic, so as to raise the question between possible cyst and chondroma. It appears to extend down into the substance of the gland behind the ramus of the jaw. The patient first noticed the growth five or six years ago, when it was about the size of a hazel nut, so that its development though constant has been extremely slow. It is freely movable upon the surrounding tissues, and gives him no trouble except by its unsightliness, on account of which he seeks advice. He states that it appears to vary markedly in size from time to time, being smaller than usual just at present. The patient's general health is excellent, and his history has nothing suggestive about it.

CASE II.—*Chondro-Sarcoma of the Parotid.*

This case presented a striking picture. A large lobulated growth, almost of the size of the fist, projecting in the parotid region, with the skin over it tense and of a dusky red colour. At the summit of the growth the skin showed a distinct tendency to ulceration under the strain, and in two or three spots upon the surface of the tumour a distinct bagginess was perceptible to the touch, suggesting localised breaking down of the tissues. The patient, a woman of 60, showed obvious signs of persistent pain and beginning cachexia. She first noticed a swelling in the left parotid three years ago when it was small and movable. For some time its increase in size was slow, but during the last six months it has made rapid strides. It is now firmly adherent and infiltrating in all directions, deeply behind the jaw, forward upon the cheek and downward along the great vessels of the neck. Three months ago the tumour was still fairly well-defined, and the question of removal was open, but now the adhesions of the growth are so firm and extensive, and its rapidly malignant character so obvious, that prospects of operation interference are decidedly gloomy. Septic absorption of the

products of the breaking down of the tumour-tissues has evidently begun already, and the mass is hot, throbbing, and painful. The question was raised whether this would be a suitable case for inoculation with Coley's fluid, but after an animated discussion the judgment both of the members and the lecturer seemed to be against its advisability.

CASE III.—*Lymph-Sarcoma of the Clavicular Region.*

J. T., aged 46, coal heaver, came to the Metropolitan Throat Hospital, October 28th, 1899, complaining of a swelling in the neck of four months' duration. No history of syphilis. On examination a large glandular growth was seen in the right supra-clavicular fossa, about the size of the fist. It was hard, fixed, and somewhat diffuse at the base, spreading downwards towards the shoulder, and extending anteriorly to within an inch of the middle line of the neck. It was painful on pressure, and pain was said to radiate from it in all directions.

Diagnosis ;—probably lymph-adeno-sarcoma ; but as a possible, but not probable, explanation was syphilis. Intra-muscular injections of solution of hydrarg. perchlor., two or three times a week, and iodide of potassium by the mouth are now being used, but without any effect upon the tumour so far.

The growth is firm but slightly elastic, markedly lobulated, and the skin is freely movable over it. To the first touch it almost suggests a rather dense fatty tumour, but it is firmly adherent at the base, and shades off into the surrounding tissues here in every direction. It has given little trouble so far except from its bulk and such pressure-pain as this renders it liable to. Its appearance raises the question of Hodgkins' disease, but there are no other glands involved except this group, and the patient's general health is robust, and his colour florid. If the specific treatment produces no effect the question of removal must be considered, though on account of the deep infiltration about its base this would be a difficult and doubtful procedure.

CASE IV.—*Double Ossiculectomy and Removal of the External Wall of the Attic.*

J. M., a missionary, aged 32, had suffered with double suppurative otitis media all his life, with a considerable amount of deafness.

As ordinary antiseptic treatment had no obvious effect upon the

discharge, the removal of the remains of the disease and ossicles was decided upon.

This was done with rigid antiseptic precautions, and the exterior attic wall cut away by means of Cheatle's burr.

The result was very satisfactory as far as the discharge went, that being completely checked, and the patient's life consequently became more secure. The hearing was not improved, but on the other hand it was no worse. The question was: were there any means by which this state of things might be remedied.

There was no stapes, the fenestrum ovale was obliterated by firm, dense unyielding scar tissue. Ordinary artificial membranes were of no value under these conditions. Several of these have been tried, including the wisp of cotton, and simple films and drops of fluid, but with little benefit. One of the purposes in bringing the case before the members was the hope of eliciting some helpful suggestions as to possible methods of relief. As the patient can barely hear loud conversational tones, he is seriously handicapped in his missionary work, but it is to be feared that little hope of improvement can be held out to him, except through trumpets or audephones acting upon the bone conduction, which is very good.

THE following Cases were shown on January 24th, 1900, by E. W. ROUGHTON, F.R.C.S.:—

Case I.—A youth, aged 20. Double congenital dislocation of hip joints. The deformity was less than is seen in many cases. This was due to the false joint not being far behind the normal position.

Case II.—A man who had sustained an oblique fracture of the upper third of the humerus; the fragments had been fixed by two wires, the position of which was shown by a skiagraph.

Case III.—A youth with deformity of upper arm. He had probably had a fracture of the humerus in early childhood, which had united at an acute angle. (Under the care of Dr. Hubert Phillips.)

Case IV.—A woman with a primary syphilitic sore on the nipple. No history of the method of infection was forthcoming.

Case V.—A woman, upon whom excision of rectum for fibrous stricture had been performed. She had been previously operated on by linear proctotomy without success. About one and a half inches of

strictured rectum had been removed, and the upper and lower parts of the bowel sewn together.

Case VI.—A woman who had been operated on for double antral empyema, and empyema of the right frontal sinus. The scar of the latter operation, being in the line of the eyebrow, was scarcely visible.

Case VII.—A girl who had been subjected to the operation of mastoidectomy for chronic otorrhœa. The discharge had entirely ceased, and the scar of the operation was only visible when the auricle was drawn forward.

Case VIII.—A man who had had chronic otorrhœa, with polypi, for many years; the right side had been cured by mastoidectomy. He now desired to have the left ear operated on. He was very deaf, but heard better with the right ear (the side already operated on) than with the left.

OPHTHALMIC CASES.

DEMONSTRATED BY HOLMES SPICER, M.B., F.R.C.S.

January 5th, 1900.

CASE I.—*Paralysis of Internal Recti with Dilated Pupils.*

A MAN of 40; began to notice some "weakness of sight" three years ago, especially for near work requiring convergence, and three months ago diplopia set in and increased rapidly. It is now constant, and the axes of eyes are permanently divergent. Pupils are dilated and immobile. There is no optic atrophy, and distant vision is normal.

The case is regarded as one of "exaggerated Argyll-Robertson pupils," with involvement of internal recti, probably of tabetic origin, although there are as yet no other ataxic symptoms or history, except a slight diminution of the knee-jerk in the right leg. The eye symptoms of tabes are usually earliest of all, and are often only temporary; may indeed be completely recovered from before the systemic symptoms of the disease show themselves. The case will therefore be watched with much interest.

CASE II.—*Rapidly Progressive Optic Atrophy in a Boy of 10 years.*

The boy's vision began to fail about three months ago, and the process has been so rapid that he can now barely count fingers with either eye.

The ophthalmoscope shows a nearly complete, pure, primary atrophy without any inflammatory symptoms, choked disc, or retinitis. The case suggests Leber's disease, or some other hereditary or family form of optic atrophy, but there is no history of blindness in any other members of his family, either among his brothers and sisters or in the two previous generations. No evidence of syphilis can be elicited, and the boy's general health is excellent. The only other morbid condition is a well-marked diabetes insipidus, from which he has suffered for three years past. So far, however, is his health from being affected by this drain, that it has actually improved during its continuance, and he has grown fat and hearty, although always a weakly specimen, and still undersized.

Treatment, as was to have been expected, has been of no avail whatever, and the case will probably soon end in complete blindness.

CASE III.—*Ptosis and Paralysis of Right Inferior Oblique.*

This case is principally of interest on account of the limited extent and capricious distribution of the pareses. The patient has ptosis of the right lid and slight diplopia. All the movements of the eyes are good, except that there is a curious "twitch" as the eyes pass the median, where, as the demonstrator expressed it, "the globe passes from the control of one muscle to the other."

The diplopia is most marked in upper third of the field, and by careful testing the defect is localised as a paresis of the inferior oblique. Both sight and fundi are normal. The patient, a man of 47, admits syphilis nearly 30 years ago, and says that the present trouble came on with an attack of giddiness and numbness of right arm and leg. No loss of power, but "a feeling as if gum had been spread over the surface of the skin and let dry." Ten years ago he had severe torticollis, which has become permanent, with atrophy of right sterno-mastoid and trapezius. The lesions are unquestionably scattered degenerative changes of syphilitic origin, but the reason for their singular distribution is quite obscure. The condition most nearly suggests some form of disseminated sclerosis.

DERMATOLOGICAL CASES.

BY MALCOLM MORRIS, F.R.C.S. EDIN.

CASE I.—*Small Multiple Ulcerations of Skin probably of Tubercular Character.*

A YOUNG man of 25 was shown, the front and inner surfaces of whose right thigh was dotted over with small patches of folliculitis. Upon closer examination these were found to have broken down in their centres into small shallow ulcers. The condition has lasted some months and resisted all treatment. At first glance it seems a very slight affair, but the glands of the groin are beginning to enlarge, and the patient's general tone is somewhat impaired. An interesting history is also given to the effect that the first lesion appeared upon the right forefinger near the nail-fold, apparently as the result of some scratch-infection, and that this was followed some weeks later by "bumps" upon the shins. The bumps softened and broke down with discharge of their contents, and on inspecting the shins several large, oval, bluish, depressed scars are found. These are evidently of what used to be described as "strunous" character, and at once raised the question whether the entire disease be not some form of cutaneous tuberculosis. Mr. Morris had seen similar cases after dragging along and giving little trouble for months finally develop into severe and extensive tuberculosis of the skin, and the case would be watched with much interest in view of its possibilities in this direction. In the meantime both local and constitutional tonic treatment would be given, although the prospects of effect from either are not specially hopeful.

CASE II.—*Erythema Induratum Scrofulosorum.*

Mr. Morris, in bringing forward this case, remarked that though conforming in many respects with Bazin's disease, yet it presented some such unusual features that the diagnosis might fairly be considered to be conjectural, and he therefore invited criticism from this standpoint.

E. B., aged 25, laundress. A little more than two years ago an indolent subcutaneous nodule had formed on the inner aspect of the left knee, and this had been excised on the supposition that it was a manifestation of local tuberculosis. Six months ago a similar nodule

appeared on the outer side of the same leg, near the knee, this had since broken down, and now presents a circular ulcer surrounded by an area of violaceous skin. In close proximity another nodule was noticed a week ago, and this now exists as a hard globular subcutaneous swelling with a dusky flush around, and very tender to the touch.

There is also a similar but much smaller one on the back of the right forearm. The patient has been obliged to abandon her occupation, which involved a good deal of standing, but her general health is satisfactory. From the standpoint of diagnosis, tuberculosis and syphilis have to be considered. With regard to the former, it appears that there is a slight family history of tuberculosis, to which, however, no great significance can be attached. Moreover, she has no other tubercular manifestations, and the local lesions differ in some points from those formerly described as "scrofulous gummata," which are apt to soften earlier and are not so tender to the touch. Congenital syphilis appears to be negatived by the absence of other signs, such as Hutchinson's teeth, old interstitial keratitis, labial fissures, and concavity of profile. There is no evidence of acquired syphilis, and lastly biniodide of mercury has had a fair trial without exerting any influence on the lesions.

Regarding the case as one of Bazin's malady, Mr. Malcolm Morris remarked that in his experience this more frequently occurred in younger subjects, that it is almost invariably symmetrical in its distribution, and that it very rarely affects the arm. The treatment recommended was rest, good feeding, and cod-liver oil.

CASE III.—*Universal Lichen Planus in a Boy of 8 years of age.*

The features of interest in this case are the youth of the patient and the profuseness and the absolutely typical character of the eruption. This began on the front of the knees seven months ago, cleared up after a few weeks, and two months ago suddenly appeared upon the chest and back, from which it rapidly spread over the entire surface of the body. Even the forehead is now covered by a profusion of pinkish, flat-topped, shiny papules. The case has been exhibited at the Dermatological Society, and pronounced one of the most striking and typical cases of lichen planus in a child. The patches range from the size of a millet-seed to that of a grain of wheat, and although

they are so closely packed together in places as to form solid pavement-like "plateaux" of elevated eruption, yet on close inspection the original papules can be seen to retain their outline and individuality.

The change in the aspect of the eruption, according to the angle at which the light strikes it, is also most characteristic; if perpendicular to the surface the papules look flat and pavement-like, but if at a tangent a distinctly vesicular appearance is assumed, so that even careful observers have attempted to puncture them and ascertain the character of the contained fluid. So absolutely universal is the eruption that there are also a few scattered papules upon the buccal mucous membrane, and the edges of the lips are cracked and fissured-looking. Only the palms and soles are free.

A fortunate feature of the case, and one probably associated with the youth of the patient, is the total absence of either local itching and discomfort or mental excitement. This latter is often singularly closely associated with lichen planus.

In a case recently under observation by the consultant, an officer in the army attacked by severe lichen planus very shortly after developed acute maniacal symptoms, and had to be put under restraint. In the course of a few months the eruption cleared up and with it the mental trouble, and the patient rejoined his regiment. Two years later, however, another outbreak of lichen took place, quickly followed by severe mental disturbances.

In another case, a lady, who suffered a most severe shock through the sudden death of her husband in a railway carriage as they were returning from the South of France, after several days of great depression, suddenly broke out in a profuse eruption, which covered almost her entire surface inside of a few hours. This was promptly followed by an attack of mania, which lasted for months. Here the lichen would almost appear to be the result of the nerve-strain rather than a cause of it, by its intolerable itching, and again the recovery from both symptoms, dermal and mental, was simultaneous. All that is known of the actual pathology and causation of lichen planus is that it is vaguely said to be due to some disorder of the nervous system.

Arsenic is the drug most relied upon in treatment, but this sometimes aggravates the symptoms. When this effect is produced antimony may often be substituted with good results. But the

drug which has given greatest relief in many cases in the consultant's experience is biniodide of mercury, although no explanation of its action can be even suggested. Its value was accidentally discovered some years ago by the chance administration of it to a patient suffering from the disease, and the surprisingly good results had been found fairly constant.

CASE IV.—*Psoriasis accompanied by End-joint Arthritis.*

A man of 47, who had suffered from severe psoriasis for 26 years, some 10 years ago developed marked end-joint inflammation in his fingers. There is a special form of the disease which appears to be associated with joint lesions. The question is an interesting one, whether the arthritis is in some obscure way due to the prolonged cutaneous mischief, by some form of septic absorption possibly, or whether the two morbid conditions are manifestations of some common factor. It suggests strongly the oft-mooted theory that psoriasis is dependent upon and an expression of the gouty diathesis. The co-existence of the symptoms may, of course, be only a coincidence. Treatment is most difficult, and little to be hoped from it, ordinarily almost useless. Good results are sometimes obtained by baths and electricity, especially with the Buxton waters. The patient has been taking arsenic and using tar locally, under which his psoriasis has improved somewhat, but a recrudescence will probably occur, and with it a fresh attack of the arthritis, as has previously occurred. The lecturer was inclined to regard both lesions as due to some form of chronic infective or other toxic process, possibly an auto-intoxication from the intestine. Thyroid feeding has been tried but with little effect. Mr. Morris had seen a very similar case which it was claimed was completely relieved by a diet of lean meat and hot water.

BY T. COLCOTT FOX, M.D.

January 29th, 1900.

CASE I.—*Lupus Erythematosus of Acute Onset.*

THE salient features of this case are the sudden onset and rapid spread of the disease and its typically symmetrical arrangement.

The patient, a woman of 39, two years ago was attacked by an erythema of the face, commencing upon the nose, of such acute

character and rapidity of spread as to closely resemble erythema multiforme. It covered the whole face, a large part of the backs of the hands, and extended in scattered patches to the forearms, as a drawing taken at this stage shows.

The acuter symptoms subsided, the disease assumed a chronic form and revealed its true character, and in this condition it has persisted ever since with fluctuations of intensity. There is now a large "butterfly patch," occupying the nose and the greater part of both cheeks, with spurs from the outer and lower angles, curiously resembling the "tails" of some butterflies' wings. There were also symmetrical patches over both eyebrows, on the backs of the hands, in the fronts of both forearms, and on each elbow. These are the diminished remnants of much larger areas of the disease, but the scars left by its recision are very thin and slight, and in most situations can scarcely be detected except upon closest examination.

The treatment of the case, as usual in this disease, has been unsatisfactory in the extreme. In the early stages, while the eruption is still spreading, the most important consideration is to avoid any form of irritating application which may aggravate the condition and hasten its spread. Indeed, a policy of masterly inactivity in this stage is sometimes better than any form of active interference.

When the condition has assumed the chronic form more stimulating applications may be employed, like the oil of cade, pyrogallie acid, and creosote plasters; but even here the demonstrator was firmly convinced that highly irritating remedies and caustics of any sort should be avoided or used with great care, or the scar left by them might be more disfiguring in its appearance than the disease itself.

Internally, salicin had proved useful in his experience, and also ichthyol in cases where much congestion was present, but he had obtained little advantage from the use of arsenic, though it has a high reputation in this disease.

CASE II.—*Mycosis Fungoides in the Ulcerative Stages in a Woman of 47.*

This case completes the typical picture of this terrible disease. Although the condition has only been present 13 months—a shorter period than in the former case—the development has been much more rapid, for the whole inner and front aspects of the left thigh are

already covered by a thick nodular induration of a dull purplish colour. This culminates a little above the middle of the inner surface of the limb in an irregular tumour-like elevation about the size of a hen's egg, which shows at its summit a small crater-like patch of ulceration. The skin of the affected area is firm, leathery, and nodular to the touch.

The disease first began upon the thigh at about the position of the tumour, and smaller patches have developed upon the breast, the right arm and shoulder, and the opposite thigh and hip, although none of these are in as advanced a stage as the primary focus. Rapid extension is taking place, and the outlook is most unfavourable. The patient, though only 47, is far from robust, and her general health is already becoming affected.

Dr. Fox pointed out that although this disease in its earlier stages was often difficult to recognise, on account of its almost eczematous appearance and the itching to which it gives rise, as was well evidenced by the abundant scratch-marks in the first case, yet its steady persistence, spread, and absolute defiance of all treatment would soon arouse our suspicions.

Histologically, the tumours are of sarcomatous structure, but yet not of any pure sarcoma type, their closest resemblance being to lympho-sarcoma, so that the name "Sarcomatosis fungoides" has been applied to the disease; but inasmuch as the tumours spread only in the skin, seldom or never become disseminated through the viscera, and the condition may last 20 or 30 years before the patients die of some septic absorption process, most commonly pneumonia, the title can hardly be justified clinically, especially as lympho-sarcoma is one of the most malignant and rapidly-disseminating forms of the sarcomatous process.

Treatment is hopelessly ineffective so far as an arrest of the disease is concerned. In short, the condition is *sui generis*, both in its appearance and course; and even in its earliest stages, closely as these resemble other and commoner forms of disturbance, it has an air about it difficult to describe, but sufficiently characteristic to lead to its recognition after four or five cases have been seen and their family likeness grasped.

CASES OF DISEASE OF THE EAR.

DEMONSTRATED BY ARTHUR CHEATLE, F.R.C.S.

December 22nd, 1899.

CASE I.—*Complete Ossiculectomy in Right Ear: Great Improvement of Hearing.*

THE patient, a woman of about 30, came originally for relief from paroxysms of sneezing, and a discharge from the ear was discovered accidentally. This had been present from childhood, and the ear was quite deaf, so that the patient had given up all thought of relief. Perforation of Shrapnell's membrane and caries of the incus were found. An operation for removal was advised, as the loss of the incus had broken the chain of conduction, and both malleus and membrane were completely useless. Ossiculectomy was accordingly done with a ring knife and incus hook, after which the hearing was greatly improved and the discharge almost completely checked. The patient can now hear conversation across the room and a whisper at 10 feet. A new membrane has reformed across the middle of the tympanic cavity, but fortunately leaving the stapes clear, so that the hearing is not impaired by it. (Both the membrane and the neck of the stapes could be clearly demonstrated to the class.)

This tendency of the membrane to reform is extremely strong, and constitutes one of the chief causes of relapse, both as to deafness and tinnitus. Mr. Cheatle stated that in a case recently operated upon by him for chronic non-suppurative otitis this had occurred within three weeks, and destroyed the great improvement of hearing secured, so that a second removal will be necessary. The operation is one of the greatest advances of recent aural surgery, and seldom fails to benefit both discharge and hearing in old suppurative cases.

CASE II.—*Caries of Incus: Natural Cure by Free Suppuration.*

The patient, a woman of 42, had had discharge from her left ear with deafness since childhood. She came under treatment some months ago, complaining of deafness and tinnitus. A large perforation of the upper and posterior third of the membrana tympani was found, through which the stapes was plainly visible, whilst not a trace of the incus was to be seen. The lining membrane of the cavity was

fairly healthy, and though there was some discharge the caries was entirely checked, probably by the complete sweeping away of the incus by suppuration. One of nature's cures, but, like most such in this affection, incomplete, and admitting of much improvement. Under thorough antiseptic treatment and syringing out of the attic the discharge has been entirely checked, the hearing greatly improved, and the tinnitus improved somewhat, though still troublesome.

She can now hear conversational tones at 20 feet. These cases were illustrated by a number of specimens of the tympanum and ossicles, showing both normal and diseased conditions.

CASE III.—*Thrombosis of Lateral Sinus: Removal of Septic Clot by Curette: Rapid Recovery.*

The subject of this case had been operated on in the Royal Ear Hospital. He was a boy of eight. He had been brought to the hospital with a profuse discharge from both ears of two weeks' duration. Some improvement occurred under treatment, but shortly after, pain in the ear, headache, and general malaise developed, and he was brought back with a staggering gait, a high fever, and double optic neuritis. He had a severe rigor while in the waiting-room, and so strong were the suggestions of septic involvement of the lateral sinus with possible cerebellar abscess, that operative interference was resolved upon at once. Within two hours the boy was placed under an anæsthetic, the left mastoid antrum widely opened and found full of the mass of caseating epithelium, sometimes called cholesteatoma. This was cleared out and the ossicles removed through the wound. At first no flaw could be found in the walls of either tympanum or antrum, but second inspection showed a black spot of necrosis in the latter, penetrating to the lateral sinus. This was then freely exposed in both directions and found packed with thrombus.

After careful exploration of the cerebellum with negative results, the sinus was laid open, and a large clot, just beginning to necrose in its centre, scooped out. Where obstruction is so complete the internal jugular below is completely collapsed and empty, so that it is not necessary to tie it, and no hæmorrhage followed the complete scooping out with the curette of the lower portion of the clot. But upon clearing the posterior portion of the sinus leading toward the torcular

Herophili a clot an inch long shot out of the wound, followed by a spout of blood.

This was promptly checked by plugging, and the wound closed. The boy made a rapid and uninterrupted recovery. He has had no return of either discharge or vertigo. His left ear stands more than half an inch lower than his right, and the gap in the skull has been completely filled by fibrous tissue, leaving a large scar-trough above the ear in which the little finger can be laid.

CASE IV.—*Adeno-carcinoma of Meatus: Fourth Operation for Removal Successful.*

This patient, a young woman of 25, had sought advice some years ago, on account of deafness and a discharge from her right ear. These were found to be dependent upon a round perforation involving the lower third of the middle of the drum membrane.

While she was under treatment for this, a white, firm sessile growth developed from the floor of the meatus, apparently under the irritation of the discharge. This was removed, and microscopic examination showed it to be of adenomatous character, but it rapidly returned. In a few months a second operation was necessary, and this time the growth was radically cleared out through the posterior wall of the meatus. Recurrence again took place, the tumour spread out on to the concha, and the patient's health began to be affected. The lower third of the auricle and the walls of the entire meatus down to the drum were then removed, since which there has been no further recurrence of the tumour. But unfortunately it proved impossible to keep the meatus from closing by scar-tissue, the discharge became dammed up and the patient began to develop mastoids symptoms. A fourth and final operation was therefore necessary, to provide drainage of the tympanic cavity. The drum cavity was opened into from behind, the membrane and ossicles removed, a small subdural abscess in the roof of the attic evacuated, and a permanent opening established behind the auricle. This remains freely pervious, and almost of the size of the normal meatus, is covered completely by the auricle, so that the ear shows extremely little deformity, except that it is much smaller and the lobule appears to have fused with the cheek. It is now 14 months since the last operation, and there has been no recurrence of the growth as yet, no enlarged glands, and the patient's general health is excellent.

REPORTS OF MEETINGS OF COMMITTEES OF INVESTIGATION.

ON DISEASES OF THE SKIN IN CONNECTION WITH TUBERCULOSIS.

(Report of Proceedings at an Open Committee.)

AN open meeting of the Committee of Investigation on Tuberculosis was held on January 24th. It had been decided at a previous meeting to take as the first subject of enquiry *the affections of the surface of the body which are believed to be in connection with the tubercle bacillus*, and as the first group of these the maladies which are associated under the name of LUPUS. A series of statements and questions respecting these had been prepared (*see* last month's Journal, p. 133), and was in the hands of those present at the meeting. A large number of portraits had also been arranged for inspection. In the unavoidable absence of Dr. Heron, the chairman of the Committee, Mr. Hutchinson undertook to introduce the subject for discussion. He said that he had understood the desire of the Committee to be to sift the facts, and supposed facts, as to the tubercular affections of the external integument, and to see whether from them any gain could be obtained as to our knowledge of tubercular affections in general. Dermatologists had been active in the collection of material, but as yet this field of enquiry had received but little attention from those engaged in the study of phthisis and other forms of visceral tuberculosis. Yet it might be supposed that the skin as an exposed surface, on which at all stages of its maladies detailed observations might be made, offered peculiarly good opportunities for clinical work. It was to these that the Committee designed to give its attention. A considerable number of skin affections had now been associated with tuberculosis. First came the apparently insignificant disease known as lichen scrofulosum; next the peculiar, and so long misapprehended, affection known as Bazin's malady, or the indurated and ulcerating erythema of the scrofulous; next various forms of ulceration, which it had been proposed to separate from the others under the special name of tuberculosis cutis; and lastly, but of greater importance, and perhaps of greater frequency than all the rest put together, a whole family of most peculiar and singularly interesting

affections known under the generic name of lupus. It was to these last that the Committee would for the present restrict its attention, proposing to undertake the others on subsequent occasions.

Having asked attention to the printed questions which were before the Committee, Mr. Hutchinson proceeded to remark that it might be convenient to briefly recapitulate the facts as to the several forms of the malady "Lupus." In doing so he would say at once that by far the most important question upon which it was wished to gain information was as to the mode by which in cases of lupus the bacillus gains access to the tissues. Do the facts favour the belief that it is always inoculated from without into the spot in which the disease first shows itself, or that it has previously existed in the blood or tissues of the patient, and is merely called into activity by the injury or other influence which immediately precedes it? This is the question of primary importance. Next to it, and bearing upon it, come the examination of the modes by which lupus, once implanted in the skin, succeeds in spreading itself in adjacent or distant parts. To these two topics he would beg the meeting to give its close attention. He would begin by attempting to place before them the principal facts respecting the form known as LUPUS ERYTHEMATOSUS. This form differs from lupus vulgaris in such marked features that some had even doubted whether the two were allied. The balance of opinion was, however, he thought at the present time overwhelming in support of the belief that not only was it a species of lupus, but that it was in more direct connection with tuberculosis than any other form. Its subjects were not infrequently themselves the subjects of lung disease, or had at some period of their lives been threatened, or were the near relatives of those who had so suffered. The evidence of this kind far exceeded in the case of lupus erythematosus any that had been collected as regards vulgaris. Yet the bacillus had been demonstrated repeatedly in vulgaris, and never, so far as he was aware, in erythematosus. The same, it might be remarked, had been observed in the case of leprosy, the bacillus being easily found in the so-called tubercular cases and seldom or never in the macular ones. Yet no one doubted that these two forms of leprosy were parts of one and the same disease, and this fact was as little questionable in reference to these two forms of lupus. The most constant phenomenon of erythematous lupus was erythema, and in the early stages, and in some cases it was almost the only one.

In these cases accumulations of cell elements in the perivascular spaces was the only structural change which could be demonstrated. Now lupus erythematosus had almost invariably its starting-point on the nose. Not usually on the tip, where vulgaris often begins, but on the thinner skin over the bridge. If patients were able to assign any supposed cause it was usually having been "caught by the sun," or it might be a scratch or an insect sting. More usually, however, the first erythematous blush had come apparently of itself, and not perhaps in one case in ten was the patient able to suggest any traumatism. Another fact as regards this form of lupus which must claim attention was that it almost never attacks young children, nor yet with the rarest exceptions those much past middle life. It occurs chiefly in adolescents and young adults at precisely the ages at which the most marked forms of pulmonary phthisis are most common.

As regards its mode of spreading, attention was asked to the fact that the first patch was almost invariably on the bridge of the nose, and that from it, by a process of infection, it spreads equally upon the two cheeks, producing the well-known bat's-wings. The infection would appear to be in part by continuity of tissue, but in part also by contiguity, for near to the parent ones, and usually with exact symmetry, others would appear which were not in continuity with it. These were the well-known discs, and might occur on the cheeks, lips, chin, and forehead, and in late stages of the malady, on the scalp, the hands, the nape, and even on the shoulders and scapular regions. That this extensive spreading was probably no indication of blood infection, and did not place the malady in any sort of relationship with exanthemata or eruptions which take their origin from within, its orderly evolution appeared to make conclusive. Several years were usually needed for the disease to reach the more remote parts—scalp, shoulders, &c.; and below the level of the bust it would appear that the infection could not spread, the lower two-thirds of the trunk and the lower extremities almost invariably remaining free. Mr. Hutchinson suggested that these facts proved that lupus erythematosus advanced its patches by infection in the substance of the skin, and not either by blood transference or by surface contagion. If its germs were transferred by the blood it ought to be universal, and if by insects or by the fingers of the patient it ought to be irregularly scattered without symmetry. It was at once symmetrical and restricted in its range, and these facts must imply

interstitial infection, spreading from a central focus of origin. There appeared, it was added, exceedingly little evidence in support of the suspicion that the primary focus was often the result of inoculation, and much which connected the disease with the diathesis of the individual and the influence of some local cause of irritation quite independent of contagion.

Many portraits were brought forward in illustration of the statements made.

Turning next to *Lupus Vulgaris*, the speaker remarked that some very different facts had been established. This form of lupus might have its parent patch on any part of the surface, although as a rule not affecting those well protected by the clothes. When beginning on the nose, it was almost invariably on the tip, or one ala, and never on the bridge. If beginning on the middle of the tip it might involve the whole nose, and spread laterally on both cheeks, producing bat's-wings like those of erythematosus. This symmetrical spreading was, however, but seldom seen, and as a rule the patches of lupus vulgaris, whether one or two or very many, were irregularly placed, and in obvious disregard of any law of bilateral symmetry. In further definite difference from what occurs in erythematosus, the patches were never evolved one after another in orderly progress, slowly extending during many years from the parent as from a centre. On the contrary, it appeared to be the fact that, in multiple lupus, the patches which followed the first one appeared tumultuously, without any order of arrangement, and often on parts at a considerable distance from the parent. The period during which production of multiplicity is possible appeared to be limited to a few months from the onset; after this, although individual patches might continue steadily to increase in size at their borders, and might evolve satellites near to themselves, no new distant foci ever made their appearance.

The earliest stages of lupus vulgaris were always difficult of recognition, from the circumstance that its peculiar features were concealed by the products of common inflammation. At later periods, when the process of infection had become quieter, a very peculiar and characteristic structure, often spoken of as apple jelly, was produced in the meshes of the corium. It was in this plasmoma that giant cells and bacilli were to be found, and it was by the

destruction of this substance that the progress of the disease was to be arrested.

Lupus vulgaris, it was strongly urged, was but seldom developed in those who were themselves the subjects of any other form of tuberculosis, and there appeared to be no danger whatever as to its proving the cause of any other. Lupus patients so seldom become the subjects of pulmonary phthisis that it might almost be imagined that the skin disease in some way protected the lungs. It was, however, quite possible that the disease might spread by continuity or contiguity to the mucous membrane of the mouth and fauces, and even involve the larynx.

Lupus vulgaris might begin at any age, and was common in young children. It sometimes underwent an exacerbation in senile periods, and might originate in them and run an unusually rapid course. Its scars were not unfrequently attacked by cancer.

As regards the cause of the first patch, there was not very infrequently some history of injury—a scratch, an insect sting, &c.—though it but seldom happened that any strong probability of bacillary inoculation could be established. The tumultuous onset of the disease when multiple, and the inflammatory complications almost always presented, seemed to make it probable that the vehicle of contagion was in association with pyogenic organisms. The presence of such in the early stages, and their subsequent destruction, might perhaps explain the tendency to multiple production which has been observed during this period. The irregular distribution of the patches suggests external contagion, that is, by the patient's fingers or by the bites of insects. It also puts out of question all idea of blood-infection. The process of local spreading which, in the case of lupus vulgaris, may last a whole lifetime, may be plausibly supposed not to differ much from that witnessed in lupus erythematosus, making allowance for difference in the precise structure in the skin which is involved.

ON THE CLIMATE, DISEASES, &c., OF SOUTH AFRICA.

A meeting of the Committee on Medical Geography was held on Wednesday, February 7th. It was an open one and was well attended. At the table of the Committee were Sir William Kynsey, in the chair,

Dr. Haviland, Dr. Joll, Mr. Hutchinson, and the secretary, Dr. Alfred Hillier. The minutes of the previous meeting were read, and the Chairman announced that the present meeting had been called to carry out a resolution to the effect that the Climate and Diseases of South Africa should be the subject first undertaken by the Committee. It was wished, he said, to collect all the information which could be got respecting the various districts comprised under this designation, and any facts which those present might be able to contribute would be acceptable. He then called upon Dr. Hillier to read his paper in introduction of the subject.

Dr. Hillier said that he must begin by making some statements as to the geography of South Africa, since it was impossible without a knowledge of it to understand the very various climates which it included. He then proceeded, by the aid of a map and some diagrams, to describe first the coast-line, next the very remarkable series of hill terraces which everywhere rise from the coast towards the interior, and lastly, the central districts or plateaus which at a very considerable elevation are enclosed by the mountains which these terraces finally constitute. His own personal experience had been, he said, chiefly in Johannesburg and Kimberley, both of them in the plateau district. Having remarked on the dryness of the air during the greater part of the year in these districts, and its generally invigorating character, he admitted that the prevalence of dust-storms was a drawback of some importance. He had been, he said, a member in Johannesburg of a medical society, at which the prevalence of severe forms of pneumonia had been repeatedly discussed, and where some had maintained the opinion that the pneumonia was directly due to the irritating effects of dust. He remarked incidentally that, so far as his experience went, diphtheria, which was very prevalent in Kimberley, was unknown in Johannesburg. Yet he believed that it was not very infrequent in the outlying homes of the Boers. He referred to enteric fever and to dysentery, but said that he was not aware that any very definite increase in our knowledge of the causes of these diseases had been obtained in South Africa. He was inclined to attach great importance to relative altitude, but felt obliged to admit that many of the facts as regards the prevalence of disease in South Africa were not to be wholly explained with reference to it. He concluded by stating some interesting facts as regards the local prevalence of disease in connection with the Bilharzia

parasite. Its prevalence was, he remarked, definitely restricted to regions supplied by certain rivers.

The Chairman, having thanked Dr. Hillier for the lucid description which he had given of the general bearings of the subject, invited general discussion, and stated that the Committee would adjourn in order to resume the subject in a fortnight's time. In the interval he hoped that all present would do their best to collect detailed information, and that they would invite any friends who had lived in South Africa, and were thus in the possession of personal experience, to come forward and place what they knew at the service of the Committee. The object of the Committee was not so much debate as the collecting and sifting of facts.

Amongst the questions and topics for discussion at a future meeting the following are some of those which were suggested in the course of the discussion:—

I. The diseases of the aboriginal inhabitants, the Hottentots, Caffres, Bushmen, &c., with especial reference to their dietetic habits, such as the almost entire absence of fish as an article of food, and the abstinence on the part of many tribes of Hottentots from the use of salt, the very large consumption of sour milk, the use of oils for the skin, and the abstinence, under many conditions quite compulsory, from washing.

II. Were the natives before the access of Europeans liable to suffer from Leprosy, and did it even at the present day prevail amongst those who were not living in association with the white population and using the fish food supplied to them from Cape Town?

[Mr. Hutchinson had suggested in the course of the discussion that leprosy was unknown among the aborigines who ate no fish, that it began when the Dutch, by the aid of Malay slaves, formed a fish-curing factory at the Cape, and that it was still spreading precisely amongst those communities to which this salt fish was now supplied.]

III. What are the diseases to be met with at the isolated farm-houses of the Boers and other colonists? Does phthisis occur?

IV. Is enteric fever ever met with excepting as the result of bad sanitation? Has its prevalence, for instance, anything whatever to do with altitude, dryness or moisture of climate, &c.?

V. What is the true nature and cause of the diseases which are classed under the name of Dysentery, and what is their distribution and relative prevalence in different districts of South Africa?

VI. If it be true that Diphtheria is common in Kimberley and unknown in Johannesburg, how is the fact to be explained? Is it simply that it has never yet been introduced into the latter?

VII. Is it the fact, as has been alleged, that cases of Sunstroke are, in spite of the great heat, unknown in South Africa, and, if true, how is it to be explained? [Sir William Kynsey, in the course of the discussion, had stated, from his experience in Ceylon and in India, that whilst sunstroke was common in the latter, it was almost unknown in the former.]

VIII. Is it the fact that exposure to the direct heat of the sun can be more easily borne both by natives and Europeans in South Africa than in most other regions, and that outdoor life is thus not only made practicable, but even attractive, under conditions of very high temperature, when the heat of rooms is close and insufferable? Is this to be explained by the fact that the air in South Africa, coast-line excepted, is almost always in motion, and that thus sultriness is prevented? Is this a general fact?

IX. In what districts in South Africa are Malarial ailments liable to occur? And what facts have been ascertained as regards the presence of mosquitos of different kinds?

X. Is cancer common (*a*) amongst the natives, (*b*) amongst the Boers, (*c*) in Cape Town itself?

XI. Have those practising in Cape Colony recognised any disease under the name of "Yaws," and, if so, what races have been its chief subjects?

ON LEPROSY.

The Sub-Committee on Leprosy held its first meeting on February 7th. Dr. Radcliffe Crocker was nominated as chairman and Dr. Joll accepted the post of secretary. Some discussion took place as to the special difficulties in the diagnosis of leprosy and the risk of errors in statistics which these difficulties involve, more especially as to the occurrence of sporadic cases. It was decided to be desirable to submit for discussion all the facts obtainable as regards the cases of leprosy which come under notice in England, chiefly, and probably exclusively, as importations from countries where it is endemic. It was thought that advantage might accrue from a careful examination of these cases

with a special regard to the possibilities as to the mode of acquisition of the malady. It was further decided that the question should be asked whether, in any single case treated in England without segregation precautions, anything like spreading by contagion had occurred.

A further subject of inquiry as to this group of cases was suggested as to the progress of the patients themselves, the degree of recovery or cure attained, &c. The Chairman, Dr. Phineas Abraham, and Mr. Hutchinson, all undertook to interest themselves in the collection of evidence on these points and to submit it to the next meeting of the Committee.

ON YAWS.

The Sub-Committee on this subject has appointed Mr. Hutchinson as its chairman, and Sir William Kynsey has accepted the office of secretary. It has held one meeting and has decided to defer for the present to invite discussion. It purposes meanwhile to collect all the printed material that it can, and to arrange and classify all portraits and photographs which are obtainable. Its chief reason for deferring any open discussion is that the subject has already been announced to be brought forward in the department for tropical diseases of the British Medical Association at its next meeting. On that occasion Mr. Hutchinson has been asked to open the debate, and not improbably most of the drawings, &c., which the Committee may collect, will then be forthcoming at Ipswich. It seems, therefore, neither necessary nor desirable to anticipate that occasion. The subject, although an important one, is after all only limited in its scope. Those interested in it will do well, in anticipation of the Ipswich meeting, to read the able essay which Dr. Nicholls (resident in St. Dominica) has contributed to Messrs. Wood's *Twentieth Century Encyclopædia of Medicine*. It is much to be hoped that Dr. Nicholls will be present at Ipswich.

NOTES ON THE MEDICAL AND SURGICAL ASPECTS OF THE WAR.

Inoculations for Typhoid Fever.

SINCE the typhoid death-rate at Ladysmith has come to equal, and upon some days to exceed, that from wounds, numerous enquiries have been made as to the history and effectiveness of inoculation for typhoid.

This procedure is being urged so forcibly by the authorities at Netley that it is estimated that two-thirds of the regular troops sent to South Africa have submitted to it. Arrangements are now being made to extend it to the Volunteers and Militia.

The first inoculations were made at Netley by Professor Wright and Major Semple in July, 1876, upon 18 army and Indian medical officers who were engaged in the laboratories there, quickly followed by those of Pfeiffer and Kolle, in Germany, two months later. The first opportunity of using them in an actual epidemic occurred a year later at the Kent County Asylum. All the medical staff and a number of the attendants consented to be inoculated, and of all these, 84 in number, not one contracted the disease, while of those who declined to be vaccinated 16 were attacked, though living under identical conditions.

A small but striking group of cases was that of eight young subalterns on their way to Khartoum, who were urged to be vaccinated. Six of them consented and passed through the entire campaign without contracting the disease, both of the others were attacked by typhoid, and one died.

It was not until last year that opportunity was afforded for carrying out inoculations on men certain to be exposed to infection upon a sufficiently large scale to justify positive conclusions. Professor Wright, with marvellous enthusiasm and industry, succeeded in finding time in the intervals of his duties upon the Plague Commission, to inoculate nearly 3,000 of our troops on duty in India.

The results of these series to date have just been published as a preliminary note in the *British Medical Journal*. The period, of course, is short, but typhoid is rife in India, causing 37 per cent. of all deaths in the British army of occupation, and many of the men vaccinated

have already been exposed to infection. These 3,000 men inoculated were selected from a body of troops aggregating nearly 11,000, all of whom have been kept under observation with the following results:— Of those not inoculated 2·5 per cent. have since contracted the disease, while of the inoculated men only 0·95 per cent. have been attacked. Of the 8,000 unprotected 0·35 per cent. have died of typhoid; of the 3,000 vaccinated only 0·2 per cent. have so succumbed. Roughly speaking, the disease-rate in the unvaccinated has been *treble*, and the death-rate *double* that in the vaccinated. This difference seems too great to be accounted for by mere coincidence, and the result is really more favourable than the actual figures indicate, since it was the younger and unseasoned men and recent arrivals in the various garrisons who were chiefly selected for inoculation, for the special purpose of protecting them from the greatest danger of their new surroundings. So that the unvaccinated group contained far the larger proportion of seasoned men, many of whom had already had typhoid.

Even as the figures stand that would, if the difference in rate proves constant, amount to the prevention of 200 deaths and 1,000 cases of typhoid per annum in our Indian army. The method certainly deserves trial on the widest scale, and the results of its application to the troops for the Transvaal will be watched with keen and most hopeful interest.

The vaccine consists of an attenuated culture of the bacilli in peptone broth which has been incubated for from two to four weeks, by which time further development of the bacilli has usually ceased.

The culture is then sterilised by prolonged exposure to heat, and standardised either by testing upon guinea-pigs, or by the estimation of the degree of its opacity, which usually corresponds pretty closely to the number of dead bacilli contained in the solution. The dose commonly used is the minimum lethal dose for 100 gms. of guinea-pig, and ranges from 0·5 c.c. to 1·5 c.c.

COLLEGE NOTES.

DURING the current month Clinical Lectures will be delivered—on the 14th by Dr. Saundby, of Birmingham, on “Non-diabetic Glycosuria,” and on the 28th by Mr. Hutchinson on “The Present Day Treatment of Syphilis.” These Clinical Lectures have proved so attractive that it has been found necessary to call into requisition the larger accommodation of the combined Library and Consultation Rooms upstairs. It is hoped this change of arrangement will prove an advantage both in the matter of comfort to the audience and of convenience to the lecturer. A short subsequent informal discussion on the subject with which each lecture deals would, in the opinion of many, be both interesting and instructive. The main difficulty in the way of adopting such a suggestion is concerned with the time that would thereby be occupied, but it is worth the consideration of the Lectures Committee whether it might not be possible to arrange for such discussion as would occupy the remaining time from the termination of each lecture till, say, 6.30 p.m.

* * *

THE first Annual General Meeting of the Polyclinic is fixed for Wednesday, March 28th, at six o'clock. The financial statement, along with a general summary of the work done at the College up to December 31st, will previously be furnished to all members. Obviously this report must be little more than a recapitulation of the initial steps taken in the foundation of the College; the few months of its life up till December having been largely occupied in organisation. Sufficient progress none the less—even under the usual initial difficulties of a new scheme—is recorded to justify us in confidently anticipating a rapid and vigorous development in all departments of our work. The first two months of the current year have done much to strengthen this optimistic outlook; and it may safely be predicted that when our second report, which will deal with a full year's working, is issued 12 months hence, it will bear ample evidence of the need for our existence, and of the value set by the profession and the public upon the work which, as a College, we have set ourselves to do. The reports will be made up annually to the end

of December, this being, for many reasons, the most convenient date for summing up the year's work, and taking stock of our position and progress.

* * *

THE Lent Session of Practical Classes commences on Monday, March 5th. The opening of the term must be thus early in order to finish before Easter. These classes are of very considerable value and deserve to be strongly supported. They are all conducted by men well versed in the subjects with which they deal, and are so arranged as to be essentially practical demonstrations and not mere didactic lectures. There has been misapprehension in the minds of some gentlemen as to eligibility for attendance. These Lectures are not reserved for the use of members only, but are open to all qualified medical practitioners. Members of the Polyclinic may lend valuable help by letting this fact be widely known among their professional friends and neighbours. A uniform fee of two guineas will, in future, be charged for the six weeks' course in each Practical Class.

* * *

TWO new classes will be found on our revised Syllabus of Teaching, viz., a practical class on "Clinical Microscopy," which will be conducted by Captain Pinch, F.R.C.S. A course of lectures on "The Administration of Anæsthetics," will also be delivered. The class upon "Morbid Conditions of the Urine and their Clinical Significance," will be resumed, provided a sufficient number of men are enrolled. Further classes will be added to our list as the need for them becomes established, but it is felt by the Council that, in regard to the two above notified, the time has arrived when they can no longer be done without

* * *

DURING the months of January and February, the average weekly attendance at the College—irrespective of the Practical Classes—has reached the encouraging total of 230.

* * *

THE Council has authorised the partial equipment of the Laboratory, which is now open for practical work. The class in Clinical Microscopy begins its first session there on the 5th inst., and it is a matter of much congratulation that it has filled so well that Captain Pinch's present

resources are hardly adequate to meet the demand. Arrangements must be completed, before next session, for more extended accommodation.

* * *

FROM this date onwards, the Laboratory may be used for independent research by members or subscribers at a weekly fee of one guinea. This sum will not include the price of material, but affords free access to all the resources of the Laboratory. Gentlemen undertaking original work are advised to provide their own microscopes, but where this is impracticable, it is desirable that they should negotiate with Captain Pinch for the hire of a suitable instrument during the term of their investigation.

* * *

IT has been resolved to utilise the Laboratory for the analysis of morbid specimens *sent by members or subscribers*. These analyses will be carried out free of charge, for the elucidation of any case brought as a patient to the Polyclinic ; but for private patients a moderate scale of fees has been arranged, the details of which may be ascertained on application to the Medical Superintendent. For the time being the Laboratory is prepared to undertake the following investigations :—

1. The Bacteriological Diagnosis of Diphtheria.
2. Widal's Serum Reaction in Typhoid Fever.
3. Search for the Tubercle-Bacillus in Sputum.
4. Search for Malarial or other Micro-Organisms in Blood.
5. The Microscopic Examination of Fæces.
6. The Histological Diagnosis of New Growths.
7. The Quantitative, Qualitative, or Microscopic Analysis of Urine.

* * *

FOUR Standing Sub-Committees of Investigation are now inaugurated and in working order. They are open Committees at which any member of the profession will be welcomed whether he belongs to the Polyclinic or not. Those having special knowledge of the subjects with which these Committees are concerned, and who may be willing to give personal help, should communicate with the Medical Superintendent or with the Secretary of the Committee which he desires to assist. At the last meeting of the Climatic Disease Committee, Dr. Hillier delivered an able and highly suggestive lecture on the diseases and

climatology of South Africa. The meeting was adjourned with a view to the fuller discussion of the many interesting questions raised by the lecturer.

* * *

THE lecture on "The Value of Tuberculin as a Remedial Agent," delivered in the College last month by Professor McCall Anderson, of Glasgow, attracted considerable attention, and has since given rise to much speculation and some doubt. Though the lecture recounted apparent success as the result of tuberculin injections in numerous cases of phthisis, lupus, and scrofuloderma, it hardly entered sufficiently into detail to enable a fair judgment to be formed as to how far the successful issue might be credited to the tuberculin reaction, because in all the cases the injections were accompanied by careful hygienic management, abundant feeding, and the administration of cod-liver oil. Moreover, it remained open to doubt whether sufficient time had elapsed, in at least some of the cases, to judge of the permanence of the apparent cure. It was also perhaps not made quite clear that the lupus patients were all without local treatment, though no doubt such was the case. These and other points upon which there might well be some divergence of opinion were touched upon by Dr. Heron in the course of a speech proposing a vote of thanks to the distinguished Professor. Throughout the lecture and reading rooms of the College there have been heard, within the past fortnight, repeated expressions of opinion that the facts *pro* are as yet too slender and the risks *con* too great to justify such a free use of the remedy as Dr. Anderson suggested when he advised every one of his audience to give it a trial, and from his own results to gauge the value of the investigations recounted in his lecture. Unfortunately there were no illustrations. Obviously the lecturer could not conveniently produce in London his Glasgow cases, but photographs, or, better still, coloured pictures, of the lupus cases before and after treatment would have appealed to the eye and done much to convince a skilled audience of the reality of the improvement which, though most clearly related, lacked in verbal description the unequivocalness that a picture or contrasted pictures never fail to convey.

* * *

THE following are some of the rarer and more interesting cases which have been shown at the consultations during the past two months:—

Lymphadenoma, antral empyema, cheiropompholyx, primary sore of nipple, Hilliard's lupus, Bazin's disease, psoriasis of nails, ectopia papillæ with iridodonesis, patency of thyreo-glossal duct, acne rosacea, central optic atrophy associated with diabetes insipidus, syphilitic epiphysitis, sarcoma of scalp, mycosis fungoides, angina pectoris, congenital dislocation of hips, neuro-fibromata, spina bifida, lupus erythematosus, narcolepsy, malignant growth in anterior mediastinum, epithelioma of cheek occurring in old lupus scar, enopthalmos, primary chancre of thumb, exostosis of ethmoid bone, beri-beri, aneurism of descending aorta.

* * *

THE Röntgen Ray plant has been moved from the second floor of the building to No. 1 lecture room on the ground floor, and the small room immediately adjoining has been fitted up as a dark room. This arrangement will, we are sure, prove of very great advantage to practitioners and patients alike, the increase of space and improved lighting facilitating the work and allowing the mode of procedure to be more readily seen and followed.

CORRESPONDENCE AND ANSWERS.

SHIELDS AGAINST BULLETS.

To the Editor of "THE POLYCLINIC."

SIR,

Apropos of your suggestion, in a former issue, of the feasibility of devising a shield to protect the heart and great vessels, it may be of interest to note that the matter is stated to be taking practical form already in the hands of the authorities. A City Councillor of Bradford, in a speech a short time ago, stated that it was within his own personal knowledge that several thousands of bullet-proof shields were now being made at Sheffield for the British infantry in the Transvaal. The shields were said to be 7 lbs. in weight, but no details were given as to size, structure, or materials of composition. The weight seems excessive, but as suggested in the description of your aluminium plate, these shields must be not only impenetrable and large enough to cover the cardiac area, but also of sufficient size to diffuse the shock of impact over a wide surface. To have a plate the size of the extended palm and fingers driven against the præcordium, with the awful impulse of a Mauser bullet stopped in mid-career, might possibly produce fatal concussion of the heart or crush in the chest-wall. A Mauser or Krag-Jorgensen

bullet is said to have penetration-impetus enough to pierce completely through a tree-trunk a foot in diameter, and the mere impact of this fearful momentum upon the chest, unless widely diffused, might be most serious. A report of the weight of your own shield, and of its resistance upon the rifle range, will be looked for with much interest.

M. D.

* * *

DUST DISEASES IN SOUTH AFRICA.

Dr. W. H. writes, referring to Dr. Hillier's lecture :—

"Some months ago, before the rains came, the reports from Ladysmith made frequent mention of a "dust-dysentery," which was extremely prevalent, especially among recent arrivals. This was ascribed to the mechanically irritating effect of the fine red dust which lay in layers upon every article of food, penetrating all ordinary cupboards and boxes, and coated every cup, plate, and spoon, so that large amounts of it were perforce swallowed daily. The attacks were sharp, and quite disabling while they lasted, attended by some loss of blood and much rectal irritation and tenesmus, but usually ended in an early recovery. And now a correspondent of the *British Medical Journal* describes an almost identical epidemic as prevailing at Modder River. The attack begins suddenly, the discharges are light green, frothy, and highly irritating to the rectum, and a good deal of blood-streaked mucus is passed. Recovery usually occurs within a week, but the disease may recur several times and is extremely weakening. As there is no rise of temperature, flatulence, or other symptoms of food-poisoning, the writer regards it as due to the irritating effects of the particles of silica inhaled and swallowed in large quantities during the almost daily "sand-devils" or dust-storms.

There certainly would seem no inherent improbability in this mechanical irritation by sharp-pointed atoms setting up severe inflammations reactions, upon which the diplococcus or any one of the scores of intestinal bacteria might engraft themselves.

In this connection it is of interest to note that a favourite method of poisoning in China is the mixing of small amounts of powdered glass or finely-chopped bristles with the food of the victim. The result is a severe and uncontrollable bloody diarrhoea, which, if the administration of the irritant can be kept up long enough, is said to ultimately wear the patient out and end in death. The plan is a fiendishly ingenious one, as the symptoms so closely resemble those of ordinary tropical dysentery, that no suspicion of foul play is aroused, even in the mind of the victim, and the chances of detection are extremely small.

* * *

J. H. sends us a string of questions *re* tuberculosis, some of which it may be of interest to answer *coram publico*. He asks :—

- (1) Has tuberculosis ever been proved in an animal living strictly in a wild state?—*Ans.* : So far as we know it has not, but wild animals in a state of confinement are very prone to its attacks.
- (2) As regards milk, has the bacillus been identified in a free state in milk, and if so, is it believed that it is derived from the skin of the udder, or may it be secreted with the milk?—*Ans.* : The bacillus has been repeatedly

recognised in milk (both by the microscope and by inoculation tests), and that, too, when no discoverable disease of the udder was present.

- (3) Is thorough cooking sufficient to destroy the bacillus?—*Ans.* : Probably it is, but it must be thorough and prolonged. Boiling kills it.
- (4) Is it believed that the bacillus ever exists free in the human blood?—*Ans.* : We do not know of any facts, but it is believed to have been recognised in the blood of oxen in a few cases.
- (5) Is the tubercle bacillus of man and the mammalia identical with that of birds?—*Ans.* : No, there are some small features of difference. That of birds very closely resembles the bacillus of leprosy.

* * *

X.Y.Z.—You are right in believing that the author of “Epidemics, Plagues, and Fevers : their Causes and Prevention” is not a medical man. The Honourable Rollo Russell has had neither a professional education nor any personal experience on the subjects of which he writes. He is, however, an enthusiastic scientist of great industry, and he has compiled a book which all medical men will find exceedingly useful for reference. It is a mine of quotations and facts which have, on the whole, been arranged with judgment. It is true that it is now seven years old, but that, perhaps, does not impair its value so much as some would have us believe.

* * *

TUBERCULOSIS IN GOATS.—In reply to an inquiry as to the alleged immunity of the goat from tuberculosis, and consequent absolute safety of its milk as an infant food, it may be stated that more recent observations do not confirm this long-held position. Both goats and sheep, as compared with cattle and pigs, are relatively exempt from tuberculosis, but both contract it fairly readily when inoculated. The first case of tuberculosis in a goat in England was recorded by one of our leading veterinary colleges 12 years ago, and since then only three other cases of spontaneous caprine tubercle have been brought to its laboratory, so that the disease is certainly far from common. One factor should, however, be taken into account, and that is, that goats, being of little monetary value, for the most part kept as playthings or by the poorer classes, and never killed for food at any of the municipal slaughter-houses, very rarely come under the care or observation of the veterinarian, so that even if tuberculosis occurred naturally, most of it would escape observation.

* * *

UNCONVINCED.—It seems improbable in the very highest degree that syphilis existed in Europe before the end of the fifteenth century. If it had been present in former ages there could not possibly have occurred an epidemic of it at that date. Yet it is on unquestionable record that there did then occur an epidemic of it which spread from the south of Europe to the north. In the course of half a century the wide-spread prevalence had ceased but the disease remained. You cannot think it possible that such a malady as syphilis should assume epidemic proportions at the present day.

We had thought that Shakespeare's reference to syphilis was too well known to need quotation. As you ask for it, however, we give it, and at the same time challenge you to produce from the writings of any earlier author, Chaucer, Boccaccio, Petrarch, &c., anything of the same kind. The passage occurs in

“Timon of Athens,” and was written presumably about a century after the of the disease to England. Timon is addressing the whores :—

“Consumptions sow
 In hollow bones of men ; strike their sharp shins,
 And mar men’s spurring. Crack the lawyer’s voice,
 That he may never more false title plead,
 Nor sound his quilllets shrilly : hoar the flamen,
 That scolds against the quality of flesh,
 And not believes himself : down with the nose,
 Down with it flat ; take the bridge quite away
 Of him, who his particular to foresee,
 Smells from the public weal : make curl’d-pate ruffians bald ;
 And let the unscarred braggarts of the war
 Derive some pain from you. Plague all ;
 That your activity may defeat and quell
 The source of all erection.”

* * *

TELEGONY is the modern term by which what was formerly known as Lord Morton’s law is now designated. It may be doubted whether it is any improvement. Lord Morton, as is well known (see *Phil. Trans.*, 1821, p. 20), bred a foal from a Quagga stallion and an Arab mare, and the hybrid, as might have been expected, bore his father’s stripes. Then comes the remarkable and unexpected fact. The mare subsequently bore to an Arab stallion two foals, which, though in the main Arabs, showed in certain stripes on their legs and in peculiarities of their manes, unquestionable features of resemblance to the Quagga. A host of facts corroborative of Lord Morton’s law have since been recorded by breeders of stock, amongst whom it is now a generally accepted creed that the peculiarities of a first husband may reappear in the offspring of the female by other males. There has not been wanting, however, a certain amount of scientific scepticism. The original paintings illustrating Lord Morton’s results are in the College of Surgeons. It has been suggested that this law may possibly explain the fact that women appear to retain the liability to transmit syphilis to their offspring for very long periods—far longer than those of the male.

REVIEWS AND NOTICES OF BOOKS.

MEDICINE AND KINDRED ARTS IN THE PLAYS OF SHAKESPEARE. By Dr. John Moyes. (Glasgow : MacLehore and Sons.)

Those interested in this subject—and who of us is not?—will find in this little volume an excellent and well-arranged citation of passages. Their number will astonish even well-read students. An introductory chapter deals with the knowledge of medicine and physiology in Shakespeare’s time, and is of great interest. The work, which extends only to 120 pages, has also a bibliography. It was edited, after its author’s lamented death, by Dr. James Finlayson, the learned author of several important essays in medical biography.

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. II., No. 4.—APRIL, 1900.

THE MONEY VALUE OF MEDICAL SCIENCE.

It might perhaps help the cause of Medical Charity, and even of Medical Science itself, if there could be drawn up a table of estimates of the pecuniary value of human life and health. We are too much in the habit of regarding the alleviation of disease merely as a matter of benevolent sympathy with our fellows. We subscribe to hospitals and the like from motives of kindness, and because we do not like to contemplate suffering without trying to do something to relieve it. Thus it is from the tender-hearted part of the public that the voluntary contributions which support these institutions are mainly drawn. There is, however, another aspect of the matter, a more cold and calculating one, it is true, but yet one of great importance, since from it may be deduced motives calculated to strengthen those of sentiment, and to appeal to others of yet more universal cogency. We allude to the value to the community, as calculable by an actuary, in coin of the realm, of human life and well being.

The recent verdicts which have been given by juries in connection with the *Stella* disaster may perhaps be made to help us in this matter. In this instance a number of persons in the prime of life were suddenly taken from their several positions of usefulness in the world's affairs, and it became the duty of the Law Courts to estimate as nearly as might be, what was the amount of loss in each instance sustained by those immediately concerned. In several the value of the life of a

middle-aged man—a lawyer, a bank manager, an engineer, or a partner in a business firm—was assessed at from £3,000 to £5,000, and in one instance, in which a wife and mother had lost her husband and eldest son, the sum awarded reached a total of more than £13,000. It does not in the least concern our present argument that, unfortunately, these sums will never be actually paid, for it is not to be suggested that, were the funds available, they are in the least excessive. They must be taken as the sober estimates, by English men of business, of the prospective value in each instance of the man's life to his family, and if to his family then also to the community, for the wages which a man earns represent the worth of his yearly services to the public.

Now, it is obviously the same to the community if a man in the prime of active life die of pleurisy or cancer, or be drowned in a fog on the Channel Islands. A life saved by the prompt skill of the physician, or the vigorous use of the surgeon's knife, is as valuable to his family and to the public as that of any one of those who just escaped drowning when the *Stella* was lost. The precise money value will of course vary with the individual, being always in relation to his earnings. An actuary would easily say what it ought to be in each case, from the director to the dock labourer. In no case could it be other than a considerable sum, and in all it would be—if we may be permitted a momentary lapse into sentiment—wholly in addition to the moral considerations of loss of a parent and a husband and an useful member of general society. It must also be remembered that death, as brought about by disease, is often a cause of much greater pecuniary loss than that by shipwreck, since it is often preceded by a long period of incapacity and an expensive illness.

A few examples may be given in illustration of our contention.

A man in the prime of life, the father of four children, and earning £300 a year, became the subject of cancer of the tongue, the diagnosis of which was not made at first. When at length it was made, the part was at once excised. During the next six months two other operations were needed for removal of glands, and after the last he remained during ten years, and up to the present time, free from disease. Surgery has in this instance enabled a man to earn already £3,000, and his gains are not yet complete. Had he died, his children would have been in orphan asylums. Abundant instances of similar triumphs in various departments of our art might be quoted, and although those achieved

by the surgeon are the most striking, those of the physician are not less real, and probably much more numerous. The pecuniary gain to the community by the prevention of premature deaths is obviously enormous and out of all proportion to the cost of the profession.

It is not, however, solely in the saving of the lives of bread-winners that medical science contributes to the nation's wealth. There are many affections which incapacitate although they do not kill. In some the incapacitation may be permanent, and in others only temporary. The shortening of the period in the latter is clearly a gain second in value only to its removal in the former. Diseases of the Eye afford us some of the most telling examples of these facts. In a recent appeal on behalf of the Royal London Ophthalmic Hospital, the following calculations were adduced :—

“There is a disease of the eye known as Glaucoma. In its acute form it usually attacks very healthy persons, those who are still in the prime of life. It shifts from one eye to the other very quickly, and if not cured it leaves its victims hopelessly, irrevocably blind. A timely operation will cure it permanently, but the opportunity, if lost, is gone for ever. Now, supposing a man who is earning £1 a week to be attacked by glaucoma at the age of 45 or 50, we may take it that he has at that age 10 or 15 years of useful, wage-earning life before him ;—let us be moderate, and state an average of 10 years. A successful operation will, therefore, save to that man, and through him to the community, £520. He will probably have been in the Hospital a fortnight, at a cost, let us say, of £1 a week, and he will probably want a month's rest afterwards before returning to work, so we must deduct £8. There still remains a clear gain of £512. Now glaucoma, although one of the most definite instances which I could quote, is only one amongst many—in some respects not one of the best, because it rarely occurs before middle age. Think of the financial value to the community which results from saving the eyes of an infant or a young child. Cataract is more common than glaucoma, and stands by its side. It, however, is again a malady which occurs only at a time of life when the further prospect of wage-earning has become limited. Let me suggest, however, that the Royal London Ophthalmic Hospital saves the eyes of 20 glaucoma patients a year, and of 400 suffering from cataract. I will take the latter at half the value of the former per case, because the patients are usually older, and the cure is sometimes less complete. Making allowance for all this, however, I estimate the saving under the ‘glaucoma’ heading to be £10,400, whilst that under ‘cataract’ comes to no less than £104,000.”

We have been dealing hitherto with the rescue or relief of individual sufferers, but the arguments employed tell with yet greater force when we come to deal with large numbers at once. Now, there are diseases concerning which it is scarcely too sanguine to predict that they will become extinct under the advance of pathological knowledge. Small-

pox, the plague, typhus, and typhoid have, in many districts, already yielded, and tuberculosis, leprosy, and malarial fevers have been well cannonaded, and stand ready for the bayonet charge. If the dictum that leprosy depends upon the consumption of badly cured fish, and can be prevented by securing a different dietary, the mitigation of human misery will be immense, and the pecuniary saving to various countries will be counted by millions. The same may be asserted as regards the prevention of tuberculosis, though, perhaps, with less definite hopefulness. If means can be devised for the destruction of the mosquito, which carries the malarial poison, vast regions of the earth's surface which are now scarcely habitable, will become so, and the saving, not only of life, but of money, will be enormous.

The gist of what we have written is this, that apart from the mitigation of distress and misery, the art of medicine has claims on the community as being productive on a large scale of national wealth. We all know how expensive a sick and delicate household is, and precisely the same is true of an unhealthy nation.

The argument, in support of which we have adduced the *Stella* verdicts, is that as we may, by the sums awarded to the victims of a catastrophe, fairly estimate the pecuniary value of the nautical skill which might have prevented it, so we may, in reference to human life and health, assign a money value to professional knowledge. We have fortunately nothing to bring forward as illustrating the defect of such knowledge in the least comparable in its appalling suddenness with what the lapse of care on the part of the captain of the *Stella* brought about. Silently, however, and in single instances, but sufficiently numerous to make up a very large aggregate, human life and health are sacrificed to defective skill. In the vast majority of instances not the slightest blame attaches to those whose failure to know what should be done and to do it at the right moment conduces to these results. The domain of disease is so vast and so varied that no human mind can be expected to grasp the whole and to be prepared for all emergencies. Many diseases, the treatment of which is very important, are in themselves rare, and afford but few opportunities for observation.

There exists amongst the non-professional public (although it may not be expressed with the bluntness with which Dogberry declared "to read and write come by nature") an obscurely defined creed, that all the essentials of the medical art are insensibly acquired in

“walking the hospitals” and are, for ever afterwards, the inalienable possession of all who have obtained diplomas. Those behind the scenes know better. They realise that unless special arrangements are made to facilitate the continued and progressive training of those engaged in the laborious duties of the profession they must of necessity fail of the attainment of what is not only desirable, but also with better arrangements quite within possibility. It is in recognition of this fact—that the medical man must remain a student, and a diligent student, throughout his life—that our countless medical journals and medical societies have been instituted. It is in emphatic recognition of this fact that Polyclinic Institutions are now being founded in all our great centres of medical education.

It is much to be desired that not only medical men but the public at large should be brought to regard these matters in the light in which we have endeavoured to show them. It is too much the habit to think of medical societies, medical museums, and polyclinics as existing only for the delectation of medical men, and those who willingly give their money to any institution which can show its hospital beds and its patients in them, may yet withhold all share of aid from institutions which aim at no higher object than the development of the skill by which such patients are to be cured. There is a not perhaps unnatural tendency to assume that when admission has been obtained to a hospital or dispensary, all has been done, forgetting that, after all, the value of these institutions mainly depends upon the knowledge of those who conduct them, and forgetting also what is of yet more importance, that if the patient could have been cured at home in an early stage there would have been no need for the hospital and the charity would have been tenfold.

J. H.

DIET AS A CAUSE OF CANCER.

IN his first Lettsomian Lecture (as reported in the *British Medical Journal*), Sir William Banks makes some interesting contributions to the study of the problem of the causation of cancer. Like most clinicians of wide practical experience in the disease, he is firmly convinced that the much talked-of increase of cancer is, in the main, a genuine one and not dependent merely upon increased accuracy of diagnosis and

completeness of registration. In support of which he quotes some pertinent extracts from his early note-books as to the frequency of the disease in the Edinburgh Infirmary in his student days under Syme, as compared with that in the Liverpool Infirmary to-day.

As to the cause of this increase, although frankly premising that it is only "an impression begotten of experience," he is strongly inclined to the view that it may be due to the great increase in the amount of food consumed by the people of civilised countries during the last half century. That this increase in both abundance and richness of dietary in all classes has occurred is indisputable, and indeed has been one of the most cheering facts and potent factors in our rapid modern development. To it has been justly ascribed much of the lowering of the death-rate, but now, according to Sir William's theory, what it has given with one hand it has taken away with the other. Children have been saved from dying by innutrition to perish later of cancer. The theory, of course, is not a new one, and it must frankly be said that our lecturer adds but little to the strength of it, except by the weight which is unquestionably to be given to an opinion from one of such wide practical experience and high standing in the profession. His first position is that cancer usually occurs in patients of vigorous physique and high nutrition. As he picturesquely puts it, patients with cancer of the tongue are "for the most part biggish, powerful men, with large, strong jaws which were hard to saw through when sawing had to be done." He admits in passing that cancer is distinctly a disease of decline of nutrition and senility, but thinks this has nothing to do with the good nourishment and vigour of the body in earlier life, indeed upon his theory its occurrence is promoted thereby. "Well-nourished, well-developed, healthy people are the most numerous victims of cancer."

He next calls attention to the fact that the increase of cancer has been synchronous with the increase of nutrient material throughout the country. Especially is this the case with animal foods in the dietary of the working classes. This argument has long been used by the vegetarians as one of their strongest proofs of the injuriousness of animal foods.

The coincidence is undoubted, but does this prove the connection championed by the lecturer? There are so many other things not directly nutritive whose consumption has also greatly increased during

this period—tea and tobacco, for instance—which, on this principle, might with equal logicality be assigned as causes of cancer. It may be true that this general over-feeding has resulted in a “widely-spread, second-rate form of gout,” as Sir William alleges, but the connection between this and cancer is not clear.

The evidence cited upon the negative side is, perhaps, a little fresher and more convincing. The usually accepted statement that cancer is as common in vegetarian and rice-eating races as in others is challenged, and the case of Ireland cited in its disproof. Here the cancer-rate has only risen in the past nine years from one death in 47 to one in 40, while in England the rate has risen from one in 36 to one in 28 in the same period. This lower absolute death-rate and slower rate of increase are alleged to be due to the less marked improvement in the living of the people. This fact would, however, be most difficult of proof. There can be no doubt that the present standard of living among the Irish peasantry is distinctly below that of the English labourer, but it has improved enormously within the past 30 years, and is still improving. Think of the contrast, for instance, between the famine days and now. The improved social and political condition of Ireland to-day rests upon a broad and substantial alimentary basis.

Nor can the next piece of evidence adduced, the marked immunity of the negro, be regarded as much more valuable. That the cancer-rate of the negro, both in Africa and in the United States, is much less than that of the white races is unquestionable. According to Billings, it is barely half as great in the Southern States, where the races live side by side. But it would be most unsafe to attribute this to the poorer diet of the negro. The negro is a born gourmand, and an enormous eater; food in that mild climate is abundant and cheap, and while in quality the coloured labourer's diet would be inferior to that of his white neighbour or employer, in quantity it would be far greater, and in actual nutritive value little if at all below it.

Indeed, in an interesting series of studies of the diets of Southern negroes, Southern white labourers, and labourers in the Northern States, recently published by Dr. Frissell in a bulletin of the United States Department of Agriculture, it is found that the food value of the diet of the Southern negro, with his abundant supply of corn-bread, sweet corn, yams, bacon, fish, and poultry, was quite equal, if not superior, to that of his white fellows, in spite of the much

higher wages of the latter. And something the same might be said of the diet of the negro in Africa; though coarse and perhaps difficult of digestion, it is, except during times of famine, abundant, relatively to the fuel requirements of the body.

So that unless we are prepared to blame an excess of animal food alone for the modern increase, it is hardly safe to cite the lower liability of the negro as a proof of the safety of an abstemious diet.

In India, where the diet generally would be justly regarded as limited and inferior in food value, there is wide difference of opinion as to the degree of prevalence of cancer, some surgeons holding that it is as common as in Europe, and all are agreed that it attacks rice-eaters and meat-eaters alike.

So that it would hardly seem as if any very clear connection could be established between the generousness of the diet and cancer in either civilised or uncivilised countries.

The third count in the lecturer's indictment of over-eating as a cause of cancer is perhaps the most original and suggestive of all. This is, that the much greater rate of increase in males than in females is related to the far greater excesses of the former in the matter of diet. He holds that the great bulk of over-indulgence is confined to the male diet, the female remaining much as before. But the question at once arises whether this difference has not always been characteristic of the diets of the two sexes. It is the man who really enjoys eating and consumes large amounts of food, patronises restaurants, and attends State dinners; the woman eats chiefly as a simple vital necessity. And unless it can be proved that this disparity of diets has increased within the past 30 years, the greater over-eating of the male would hardly be competent to explain the recent increase of cancer in that sex. Certainly the food-range of woman has markedly improved in the past 30 and especially the past 10 years, perhaps relatively almost as much as that of man.

The further fact urged in favour of the theory that the prevalence of cancer is greatest among the most prosperous classes, as shown by Roger Williams, is of course susceptible of several other explanations, as so many factors are here involved, prominent among which is increased longevity.

In fine, it would really seem that increased consumption of food may possibly be a predisposing cause of cancer, in so far as it promotes

survival to the cancer age, but that otherwise its relation to the increase of the disease has not as yet been shown to be probable.

W. H.

ON YAWS.

OUR Committee of Investigation on the subject of Yaws has decided not to sit until after the meeting of the British Medical Association next August, at which this malady is put down to be the subject of a special debate. This, however, is no reason, but rather the reverse, why we should not make some attempt to introduce the subject and to clear the ground by a statement of such facts as are supposed to be established respecting it. With this object we give in our next number a review of the article on "Yaws," by Dr. Alford Nicholls, published in Wood's *Twentieth Century Practice of Medicine*. It is possible that there exists in the English profession respecting this disease a sentiment which amounts almost to one of repulsion, and the avowal "I know nothing about it" is sometimes made in a manner which suggests a suppressed "and I do not want to know." The very name is mysterious and ugly, and there is a general impression that it concerns a malady yet more disgusting than syphilis, and not necessarily of anything like the same interest as a field for pathological study. This impression is to some extent correct, and yet it is a pity that it should prevent those amongst us who have leisure and zeal from undertaking an examination of the facts. They do indeed present a very curious and important problem for the student of circumstantial evidence in matters of pathology. We will endeavour to state it with brevity, and without prejudice.

In various tropical and sub-tropical regions there occurs a malady which has for its most conspicuous symptom a general eruption of scaly papules which develop into granulation masses more or less resembling a raspberry or mulberry. This eruption lasts a few months, is often attended by much aching in the bones and joints, by slight general enlargement of glands, and in some cases by fever. It will disappear spontaneously, and usually leaves no scars, but relapses and complications may occur. It is not supposed to be infectious, but to spread by contagion to abrasions or sores. Experimental inoculations

have been made on a rather large scale, and the results have been very uniform. There is an incubation period of about a month, then a "mother-yaw" forms on the site of inoculation, the proximal lymphatics enlarge, and in a few weeks the eruption follows. Children are most frequently its subjects, but it may occur at any age. Formerly one attack was held to prevent another, but this is now denied. It was even asserted that in some countries mothers inoculated their children intentionally, holding that it was better to get it over. A slave who had had Yaws was worth twice as much as one who had not. Although it may affect individuals of all races, it is generally admitted that negroes present it in its most typical form. As regards the influence of mercurial treatment, almost all agree that it represses the phenomena, but many allege that relapses are common. As regards sequelæ observers differ much, but many have alleged that bone disease and lupoid affections of the skin are common. The problem clearly is, Are we to count Yaws as syphilis modified by race and climate, or is it a distinct disease? At first sight it is very like syphilis, and the assertion that in some regions it appears to supplant syphilis and that the relative prevalence of the two is usually in inverse ratio, gives support to this view. Sydenham proposed for it the name *Syphilis Æthiopica*, but from his time forwards those who have investigated it have been divided in opinion as to whether it is syphilis or not. It should be here stated that there is evidence in support of the belief that it was extant amongst the Africans when the Gold Coast was first visited, and also in the West Indies when Columbus landed, and that it has had independent centres in the Feejee Islands, in Ceylon, the East Indies, and perhaps many other places. It is perfectly clear that if it be not syphilis it is a malady of a very similar character, conveyed by contagion only, observing parallel stages and presenting very similar phenomena. Those who in the present day deny that it is syphilis rely upon the asserted facts that the eruption is always the same, and different from anything which is seen in syphilis, that sore throats do not occur, that an attack of Yaws does not prevent one of syphilis, and that there is never any proof of inheritance. Other minor features of difference are alleged, but these are the more important ones.

J. H.

OPEN-AIR TREATMENT IN EXCELSIS.

IF any belief be more firmly fixed than another in the popular, if not indeed in the professional, mind it is the harmfulness of "night air," and the desirability of avoiding it as much as possible. The new open-air treatment of consumption has done much to shake this article of faith, by its insistence upon open, or even glassless, windows in bedrooms at all times of the year. But the finishing touch to the defiance of this prejudice has just been reported as given by a New England physician, Dr. C. S. Millet, of Brockton, Massachusetts, in the *Maryland Medical Journal* (quoted in the *New York Medical Journal*). In five cases of well-developed pulmonary tuberculosis, occurring among his poorer patients, who were unable to seek change of climate, he advised sleeping out of doors, all night, without even an awning or roof over their heads except in rainy weather. With a sublime confidence, which was a high compliment to the doctor as well as to their own courage and intelligence, these patients arranged beds on the roofs of their houses, in which they slept under ordinary bed-clothes, wearing only soft felt hats in addition to the ordinary night-dress.

In all five cases the results are said to have been remarkable. Improvement began within two weeks, the cough disappeared, the temperature fell to normal, and a marked increase in weight occurred.

Dr. Millet thinks that dampness and draughts may be practically disregarded, and that heavy dews were disadvantageous only as necessitating the drying of the bed-clothes in the morning. His results as reported are certainly so remarkable that one would like to see them verified and further corroborated before accepting them as convincing proofs of the correctness of his theory. Still they coincide quite closely with the beneficial results of, what seems at first sight reckless exposure to the weather in the daytime, on the part of invalids in our modern sanatoria for tuberculosis.

W. H.

ARTIFICIAL PRODUCTION OF GOUT IN BIRDS.

AN interesting report has recently been made by Kionka, in the *Berlin Klinische Wochenschrift*, upon a new method of producing gout in birds. As is well known, this may be done by ligating the ureters or by the ingestion of chromic acid, but Kionka preferred to attempt it by affecting the nutrition. This was done by feeding a group of hens upon an exclusive diet of lean horseflesh and water. The birds at first thrived on this, but in about three months' time symptoms of gout began to manifest themselves. The hens became unsteady in their gait and tender in their feet, the joints became swollen, and the patients would lie on the ground unwilling to move, with their legs drawn up under them. These symptoms came in paroxysmal attacks at first, but soon became constant, the appetite began to fail, the feet remained swollen and crippled, and the birds lost weight rapidly, and finally died. There were well-marked uratic concretions in the swollen joints, and between the tendons of the legs and feet. In many of the autopsies deposits of urates were found in the peritoneum, and uric-acid infarcts in the kidneys.

During their illness the hens showed a marked craving for lime, and when this was supplied to some of them they ate greedily of it, and at the same time drank enormously increased amounts of water. The result was a great increase in the bulk of their excrement, and a diminution of 35 per cent. to 50 per cent. in the amount of uric acid excreted, which would appear to indicate that the lime either enters into combination with the acid nitrogenous compounds, neutralising them and promoting their elimination, or in some way promotes the formation of the urea group or the urates instead of the acid and irritating uric acid. That this was its *rôle* in the human body has been suspected by several observers, although denied by others, and Van Noorden has recommended the use of lime in the treatment of the uric-acid diathesis. Its effect must be produced indirectly, and one should certainly hesitate somewhat in reasoning from its results upon the bird organism, where the tendency is for the great majority of the nitrogenous excreta to assume the form of the uric-acid group, to its effects upon the mammalian, where the normal tendency is equally strong in the direction of the urea group.

W. H.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON RHEUMATOID ARTHRITIS, CONGENITAL OBESITY, AND NEURASTHENIC TREMOR.

BY J. F. PAYNE, M.D., F.R.C.P.

February 14th, 1900.

GENTLEMEN,—Our first case is one presented for consultation by Dr. Stewart. It is an example of rheumatoid arthritis in a girl of 19, and is of special interest on account of the youth of the patient, and at the same time the unmistakable character of the disease. The beginning of the trouble dates back even to her fourteenth year, when she began to be troubled with severe cramps in her leg-muscles and stiffness of her knees. Curiously enough these attacks coincided with the appearance of her menses. Her history is devoid of any features of special interest, nor is there any record of similar disturbances or any possibly contributory conditions in any members of her family. She has always been considered delicate, but has never suffered from any severe illness. Our patient might possibly be said by a certain school of etiologists to have family tendency to both cancer and tuberculosis, as one of her grandfathers died of the latter, and one of her grandmothers of the former disease. But if you will remember that a family group covering three generations is safe to include from 20 to 30 persons, it can be seen at once that these deaths would represent no more than the average rate from these diseases of the community at large. The mere occurrence of cases of even inheritable disease in a patient's family is in itself no proof whatever of hereditary tendency to any disease, unless distinctly above the general average for the size of the family-group.

The most striking lesions of the disease are to be seen in the hands, in which almost every phalangeal joint and in the right the knuckles and wrist are characteristically enlarged and stiffened. Upon the fingers of the right hand may be noted three well-marked osteo-arthritic nodes,

and the joints are swollen, not merely from overgrowth and "lipping" of the articular margins, but also from some synovial effusion. In the left hand there is less articular swelling but even more stiffening, an ill-defined nodular condition can be felt in both wrists, and a curious prominence with mobility of the lower end of the ulna seen, due partly to bony enlargement and partly to displacement by the pressure of fluid effused into the joint. Most characteristic, however, is the extensive muscular atrophy present. This affects chiefly both sets of interossei, notably the dorsal, causing a distinct hollowing between the metacarpal bones. This is especially well marked in the short muscles between the thumb and index, the rounded prominent fold, which should run along the radial side of the interval when the thumb is drawn in, has entirely disappeared, giving the hand the narrow, ape-like appearance described by several observers, and especially dwelt upon as characteristic of the disease by Charcot, who called it the "Simian" type.

The muscular wasting is doubtless primary and not due to disuse. In the hands it is distinguished from the "claw hand" of progressive muscular atrophy by the comparative absence of wasting in the thenar and hypothenar eminences, and of hollowing of the palm, as well as of any permanent flexure in the fingers, all of which changes characterise that deformity.

Tracing the muscular atrophy upward we find the forearm slightly though distinctly affected, the arm much more so, especially the biceps, and the shoulder muscles strikingly wasted and flattened. The spine and the acromion process stand out in bold relief with hollows both above and below them.

The feet show thickenings about the joints of the toes, similar to those upon the hands, but less marked and causing less crippling. The knee joints seem but little affected, although walking is much interfered with by painful cramps in both the calf and hamstring muscles, and this was one of the first symptoms noticed by the patient.

No grating is to be elicited in any of the larger joints as yet, showing that the disease is in a comparatively early stage, in spite of its nearly five years duration.

The nature and causation of this distressing disease are still most obscure. The theory of a constitutional or diathetic origin, though perhaps most plausible of any, is hardly sufficiently sustained, and there is usually no history of precedent illness.

There is a possibility that the disease may have its starting point in some form of traumatism, whether mechanical, as from a blow or fall, or toxic, from a gonorrhœal or rheumatic infection. There are many things about it which suggest a distinct specific disease with a bacillus of its own, as described by Dr. Wohlmann and others, but of this we have no positive evidence as yet. In any case the characteristic lesions of the disease, like all other joint affections, seem most likely to be secondary, dependent upon some precedent systemic disturbance. It is hard to imagine the joint mischief as an initial lesion, affections of the synovial sacs and articular surfaces must almost in the nature of things be secondary to changes in the blood from general or systemic disturbance.

As for the treatment, rest in bed, good feeding, and cod-liver oil are the principal measures, although in some cases quinine in large doses gives great relief, and seems to act in some obscure way almost as a specific.

Unfortunately, the younger the patient the poorer are the prospects of a permanent arrest of the disease; and in a case beginning at such an unusually early age, the outlook is most unfavourable and the disablement will probably steadily progress, though life may not be in any way shortened by it. Still some cases make most unexpected recoveries, and I have seen a man with a knee swollen to the size of a cricket ball, and a leg below it wasted to the size of a wicket-stump by contrast, get almost completely well under treatment. The Tallman hot-air treatment I have had no experience with personally, but some remarkable results are reported from its use.

Our next case is one of extreme congenital obesity in a young woman of 22. This singular case is brought for consultation by Dr. W. H. Day, who gives us the following history and description:—

The patient, Miss A. H., is a first-born child, and was noted as very large at birth. The physician in attendance estimated her weight at 20 lbs., but no formal record was taken at the time. There is no history of obesity in either the father or the mother's family. Both parents are of average size and well-proportioned, the mother being the larger of the two. The mother gives as her only possible suggestion of the cause of the obesity the curious story that during gestation she drank some seven bottles of olive oil on the advice of a friend, who said it would

give her an easy labour! And ludicrous as the means adopted, the desired result actually followed, and the labour, in spite of its being her first, and the child of great size, was an excellent one.

At three months old the child weighed 35 lbs. and was then weaned, and put upon a prepared infant's food in the hope of its proving less fattening than the mother's milk, but it still continued to increase in weight at nearly the same rate. At 12 years of age the girl weighed 13 stone; at 15, 16 stone; at 20, 20 stone 4 lbs., and now at 22, a trifle over 21 stone, her weight and the years of her age having thus run in oddly parallel curves.

She has always been a moderate eater, never specially fond of sugar, milk, or other fattening articles of food, is now, and has always been, a picture of health and vigour, of good mental powers, and cheerful disposition.

This history, and the bright, vigorous appearance of the patient clear the ground of several possible causes of obesity, among them heredity and myxœdema. Our first question would be as to the existence of some possible arrest of sexual development, which is not infrequently accompanied, in young girls, by excessive deposit of fat. But, upon inquiry, she states that her menstrual flow began at 13 years of age, and has been regular ever since.

Then it is by no means uncommon for an adiposis to develop in girls in connection with the well-known anæmia of puberty, and apparently as a result of the sub-oxidation consequent upon this hæmic condition. But these patients are usually pale and languid, instead of ruddy and vigorous as this girl, who says that she walks three or four miles a day with ease.

But the entire history of the case, the large size at birth, and steady increase of the condition with each succeeding year, showing that the tendency toward, if not the actual adiposis itself, was present at birth, all point strongly toward its being of the nature of an aberrant congenital tendency to overgrowth, like giantism. It has probably been very little affected by any post-natal influence, and will, we fear, be equally little amenable to treatment of any sort. Fortunately, however, except for the burden of the additional weight, the condition is not a serious, perhaps scarcely, even, a pathological one, as the patient is tall, well-proportioned and vigorous, and suffers very little discomfort, except from the effects upon her appearance.

Thyroid feeding does good in some of these cases, and should be tried, although, so far as the gland itself can be made out, embedded as it is in the rolls of fat upon the neck, there is little abnormal to be discovered about it, though changes would be very difficult to detect under the circumstances, unless very well marked. As recent researches appear to show that much of the effect of thyroid extract is due to its contained iodine, its action may be similar to that of iodide of potassium, which has so long had a reputation in the treatment of obesity, and might be tried in case of the failure of the extract.

Careful regulation of the diet combined with massage, the encouragement of perspiration, and strict limitation of the amount of fluid taken with the food are useful in many cases, but we fear would have little effect upon one of so obviously congenital and "overgrowth" character as this.

Our third case is one of tremor of the hands in a young man of 22, a member of the Salvation Army. He states that the trembling is not constant, but, under embarrassment or excitement, severe enough to prevent his writing. There is at present no trace of it to be seen or felt, even when both hands are held out horizontally with the eyes closed, so that the disturbance is evidently a functional one, and probably neurasthenic, if not hysterical. The patient admits occasional fits of low spirits, and is greatly worried about the symptom, which he is sure is the beginning of some serious disease. He has been overworking and over-exerting himself, the reaction of depression has set in, and a slight functional trembling has preyed upon his mind, and of course been aggravated by the very importance attached to it.

We sometimes speak of these cases as "imaginary," but they are extremely real to the patients, whose tendency to attach exaggerated and even absurd seriousness to trivial symptoms, is simply a part of their disease, for which they are often in no real sense responsible. Assurances that their fears are unfounded, the prescription of an iron tonic, and urging them to secure plenty of exercise in the open air, which will make them both eat and sleep better, will often relieve both their fears and the exhausted and even toxæmic condition of the nervous system which is the basis of them.

ON CASES OF CHOREA WITH HEART MURMURS; PERSISTENT COUGH AND VOMITING DUE TO IRRITATION OF VAGUS; DISPLACEMENT OF THE HEART BY CONTRACTION OF TUBERCULAR CAVITY, AND OTHER CASES.

BY SIR WM. BROADBENT, LL.D., F.R.S.

[From Notes by Dr. J. D. P. McLATCHIE.]

March 6th, 1900.

GENTLEMEN,—Our first case (sent by Dr. Owen Mead) is an obscure one, probably of bands of adhesions radiating from the under-surface of the liver and compressing the pylorus, of traumatic origin.

The patient, a man of 52, gives no history of previous illness, except a brief attack of jaundice six years ago; but a little more than a year ago he met with a severe accident, in which four of his lower ribs were broken, and he was unconscious for a week. The liver may have been ruptured.

Since that time he has complained of almost constant pain in the right hypochondrium, of a sharp, shooting character, radiating across the abdomen and up the left side, and worse after meals. There has been little or no vomiting, but he frequently has attacks of flatulence during which his abdomen becomes much swollen, and he suffers constantly from severe constipation.

Upon examination there can be felt, just below the edge of the liver, at about the junction of the epigastric and right hypochondriac regions, a localised resistance, which is apparently due to a series of bands of adhesions. These seem to be attached to the liver at their upper end, but their precise relations and attachment below are difficult to make out. They are, however, sufficient to account for most of the symptoms of which he complains, and, by compressing the duodenum and pylorus, probably give rise to his attacks of flatulence.

I should recommend an exploration, having seen good results in other similar cases.

Our next two cases are of interest, as illustrating the relation between cardiac lesions and chorea. Two sisters, aged 14 and 19

respectively, one of whom had chorea 10 years ago, and the other is now obviously suffering from a typical attack. Hands, feet, and facial muscles are all actively involved, the attack beginning five weeks ago in the left arm and leg, and affecting the speech last of all.

Upon examination, we find a slight but distinct mitral systolic murmur, and also a faint pulmonary systolic sound, which latter, however, is probably hæmic, and of no special significance. We evidently have to do with a case of early endocarditis, probably of rheumatic origin.

In the older sister the attack was much more severe and the resulting lesions more serious. According to her statement, she was in the hospital for four months with rheumatic fever and "St. Vitus's Dance" at one and the same time. If anything, the chorea would appear to have preceded the cardiac symptoms of the rheumatic attack. Usually where the chorea develops during or in rapid succession to the acute rheumatic seizure, it is apt to prove of a very severe and dangerous type.

There is an interesting combination of cardiac murmurs. The apex beat is exaggerated and displaced outward, and there is distinct right ventricular pulsation in the epigastrium. The well-marked apical murmur is double, a long, loud, rough pre-systolic occupying almost the whole of the diastolic interval, followed by a slighter and smoother systolic murmur, with reduplication of the second sound. The condition is mitral stenosis with incompetence.

This is one of those cases which it would seem impossible to reconcile with the theory of the systolic origin of the pre-systolic murmur, as the latter here occupies the entire diastolic interval, so that it cannot be regarded as an effect of systolic regurgitation.

If we represent the sounds of the heart by short vertical lines upon the blackboard, here thick and there thin alternately, to correspond to the broader first and sharper second sounds respectively, the pre-systolic murmur would appear as a broad bar of rough shading, swelling up to the line of the first sound. When prolonged, as in this case, it often gets fainter in the middle of the diastolic interval, or may even divide into two portions, the first being due to the suction action of the dilating ventricle, the second to the contraction of the auricle.

When the left auricle becomes much dilated and enfeebled such a murmur may disappear, leaving only a short, sharp first sound, but as

the patient rallies and contractile power improves, the murmur gradually returns.

Our fourth case (sent by Dr. Pike) is an unusual form of persistent cough and vomiting, due to pneumogastric irritation. A young man of 28 began rather suddenly to be troubled with cough, followed by vomiting, nearly five years ago, and has been subject to frequent attacks of it ever since. A singular feature about the case is that the paroxysms are not brought on by lying down or by taking food, but rather by moving about, or vigorous exertion of any sort. If the patient lies or sits still, he is quite comfortable and free from attack. The coughing is violent but there is no expectoration, except a little frothy mucus, and the matters vomited are seldom more than a few ounces of thick, ropy mucus. Fortunately most of the attacks come on some hours after meals, so that he does not lose his food, and his nutrition has been scarcely at all affected, even in the course of five years, nor has he lost weight to any appreciable degree. The cough is most atypical, in that lying down—which, in most forms of cough, whether pharyngeal, laryngeal, or pulmonary—is the signal for a paroxysm, seems to relieve it. So that, even if we should find an elongated uvula or other form of local predisposing condition, we should have to search for yet another factor, and this can hardly be other than some form of vagus-irritation. The first suggestion which would occur to the mind is pressure of enlarged bronchial glands, and we will proceed to an examination of the chest, to see if any other evidence pointing in this direction can be elicited.

The lungs expand well, but there are signs that the right apex has been the site of tubercular disease, which is, however, not active at present. Over the posterior aspect of the upper lobe of the right lung there is a loud expiratory and inspiratory murmur (the inspiratory the louder of the two), such as might be produced by the pressure of an enlarged gland upon the bronchus supplying the area. In the interscapular region is a small patch of dulness.

Taking all these symptoms together, the case is probably one of irritation of the pneumogastric, by the pressure of enlarged bronchial glands at the root of the right lung, and the outlook for relief not very promising in view of the length of time which the condition has already persisted. The general health should be kept at its best

by means of good food and fresh air, and, if necessary, tonics, so that the irritation may be resisted. Occasionally, however, these enlarged glands break down, rupture into a bronchus, and are coughed up, so that recovery results, as in a patient recently seen by me, but this is a rare termination.

Our fifth case is one of extensive destruction of the upper part of the right lung, with consequent displacement of the heart, in a young man of 26. He is brought here by Dr. Macrae, who kindly gives us the following history :—

The patient has suffered from recurring colds since early in 1895, with some shortness of breath and yellowish expectoration. A year ago he had a sharp attack of pneumonia, and three months ago of influenza, during which he had claret-coloured expectoration for several days. He was first seen a few days after the beginning of the influenza, and was found to have a temperature of 103° , pulse 120° , great dyspnœa, lividity of face, and vomiting. The lungs were literally “water-logged,” and he was bringing up quantities of yellow, grumous sputum amounting to nearly a tumbler-full a day. Stimulants and stomach sedatives were given, followed by guaiacol camphorate, under which he rapidly improved, so that now he is almost free from cough, has a good appetite and colour, and goes out daily.

Upon inspection it is obvious that the right side of the chest is distinctly flattened. This might be due to pleuritic adhesions, but if that were the case we should have great impairment of movement, if not complete immobility of that side of the chest, while here the respiratory rhythm is but little affected. The heart is clearly displaced, and dragged over toward the right, but the left lung does not appear to have followed it fully. There is a splendid example of cavernous breathing over the upper part of the right lung, peculiar in that the inspiratory murmur is strikingly tubular. Over the lower portion of the lung we find well-marked bronchophony, and the entrance of air is very imperfect.

The condition is just as Dr. Macrae described it, extensive destruction of the upper portion of the right lung, which is now occupied by a gigantic multilocular cavity, over which all sorts of variations of inspiratory and expiratory murmurs can be heard by simply shifting

the position of the stethoscope. This cavity, by its fibroid contraction, has dragged the heart over to the right side, and flattened in the chest-wall.

The patient looks surprisingly well and vigorous, but he has a distinct trace of myoidema in the muscles of his chest. This is a valuable sign for distinguishing between recent and long-standing febrile processes. In actively progressive tuberculosis you can raise a distinct nodule in the substance of the pectoral muscles merely by a sharp tap or pinch. Here the reaction can be most clearly seen in the biceps. This is simply an abnormal irritability of muscle fibres, from wasting under fever.

Climate of Natal.—The summer in Natal is a season of frequent heavy rain and cloud, and thus the heat never rises to tropical fierceness. The winter is genial and June-like. “This,” says Dr. Mann, “is exactly the opposite to what obtains at the Cape of Good Hope. The summer there is a season of scorching and drying heats, and the winter one of wetness and cold. The prevailing wind in Natal is from the sea, bringing air loaded with vapour. Within 70 miles of the coast nearly a mile of ascent has been attained, and clouds are formed, to be followed by rain. Maritzburg stands 40 miles from the coast, and two-thirds up the slope. Almost every day after noon in summer the sky becomes cloudy, and remains so until far into the night. Thunderstorms are very frequent. The land wind is hot and dry. Excepting when land wind prevails the summer temperature at Maritzburg is rarely above 85°. The hottest months of the year are from October to March, and the winter is from April to March. It must be remembered that winter is a period of almost unbroken sunshine, but not extreme heat; summer, one of heat tempered by clouds and thunderstorms. The mean temperature for the winter months is 60°. Even in the uplands it is common to build houses without fireplaces except for cooking. Thus it will be seen that the seasons in Natal are very remarkably compensatory, and the unusual circumstance that the period of greatest heat is also that of greatest rainfall renders the vegetation extraordinarily luxuriant.” Dr. Mann states that the impression made on a Cape Colonist when he first visits Natal is akin to that experienced on going into a well-kept garden. The rainfall at Maritzburg is nearly the same as in London. “Most sicknesses in Natal occur in the cold period following on great heat. I have no doubt that the so-called Natal sores are produced by the depressing influence of chill. . . .”

ON CASES OF PHTHISICAL CAVITY OF UNUSUAL SHAPE AND POSITION; ARTHRITIS DEFORMANS; FORMATION OF SECONDARY TUBERCULAR CAVITIES; TUBERCULOSIS AND TRAUMATISM.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

[From Notes by Dr. J. D. P. McLATCHIE.]

GENTLEMEN,—Our first case is one of phthisical cavity followed by remarkable alteration of its original position, due to contraction of the lung. The patient, a lad of 13, gives a significant family history. His father is healthy but his mother suffers from an affection of the chest, which, from the description given of it, is probably tubercular, three sisters and one brother died in infancy from measles, whooping cough, and pneumonia respectively, while of two surviving sisters, one has a cough.

The father declares that our patient has suffered from his present trouble “practically from his birth.” He has a cough and a moderate amount of expectoration containing tubercle bacilli, but not fœtid, or at most only slightly so at times, though occasionally streaked with blood. Shortness of breath, night sweats, capricious appetite, and emaciation complete the picture. Vomiting frequently occurs as a result of paroxysms of coughing.

We find the left side of the chest flattened in both upper and lower portions, and unable to expand well. The left shoulder is depressed, the area of the heart’s dulness is small, and the heart is slightly drawn up. Anteriorly there is harsh breathing, as over a hypertrophied lung; posteriorly there is dulness over the upper third of the left chest.

Cavernous sounds can be heard over almost the entire length of the lung from near the apex to the base. These are due to a long sinuous cavity extending through both lobes of the lung. The right lung is not affected in any way.

In all probability the present position of the cavity is not its original one. At first the sounds would have been heard best at the front of the chest, just below the clavicle, but as the lung contracted the

situation of the cavity became altered, and, as is often the case, it comes to be heard best at the back, in the interscapular and scapular regions.*

The possibility of bronchiectasis has been suggested in this case, but in bronchiectasis we have a large chest, emphysema, loud breath sounds, and areas over which cavernous sounds are heard, but where it is difficult to localise the lesions exactly. Here we have a long sinuous cavity which is easily localised, and over the entire length of which the cavernous sounds are heard clearly. Moreover a bronchiectatic cavity would be situated nearer the base, and would probably be multiple, while the sputum would be abundant and foetid. The prognosis is favourable and little treatment is required, except to assist nature.

Our second case is one of osteo-arthritis in a woman of 58, sent here by Dr. Richardson for an opinion. Her history shows little of significance: the mother of five children, she has had no illness previous to the present one, which began five years ago with pain in the ring and little fingers of the right hand. These soon became stiff and difficult to flex, and gradually other fingers became affected, until she was unable to close the hand, and pains began to be noticed in the wrist joint.

For the condition of the hand an operation was performed at the London Hospital, but with little benefit, and while in the hospital she began to complain of pain and swelling in the abdomen. The condition of both these regions gradually grew worse, and in addition a ganglion-like swelling appeared in the right forearm, just above the wrist.

About three years ago the disease appeared in the right tibia, which began to bow and caused her to limp. At present the pain is not severe, but the left leg has also become affected, and is drawn up.

Lately the characteristic pain has appeared in the right thigh and in the back. In the latter, at about the level of the tenth dorsal vertebra, the patient feels a grating sensation on movement.

The woman is evidently exhausted and in poor condition. Both her tibiae, especially the left, are bent outward, and the shins are much thickened, as if from periostitis. The bridge of the nose is also thickened, while over the two lowest dorsal vertebrae there is tenderness and on auscultation distinct grating can be distinguished. The pain complained of in the stomach seems probably due to a distended colon and not to any manifestation of the general disease.

* See THE POLYCLINIC, vol. ii, No. 2, p. 91, "On Tubercular Cavities," &c.

The urine contains neither albumen nor sugar, but crystals of urate of ammonia are present.

In the differential diagnosis two possibilities at once suggest themselves, osteo-malacia and syphilis. The former is pretty completely negatived by the entire absence of any softening of the bones, but the appearance of the shin and the night pains would fit in very well with the latter. There is, however, no specific history, no miscarriages or other manifestations, and, so far as can be learnt, the husband is healthy.

In spite of the absence of secondary enlargements round the joints and other atypical features it is probably a case of osteo-arthritis or osteitis deformans, the process having manifested itself chiefly in the shafts of the bones.

Arthritis deformans is a secondary disease, whose development depends upon a condition of malnutrition in the patient. This would account for its preference for the victims of chronic gout, or of old long-standing tubercular processes. It may often be seen in children, in whom it usually begins in the dorsum of the foot and gradually spreads to other joints.

The chief features of the joint-changes are ulceration of the cartilages, beginning at the circumference and extending to the centre, laying bare the articular surface of the bones, when these become hard and eburnated, and lips of bone form around their margins, causing enlargements and ankylosis. It is to be noted that many of the enlargements in gouty joints are of this nature and not composed of urate of soda.

The prognosis is unsatisfactory, as the changes usually spread to other joints, and the patients become slowly but surely crippled and deformed.

As to the treatment, cod-liver oil, iron, and arsenic are all useful. The last-mentioned is often of distinct service, especially if persevered with, until its characteristic effects appear, as it is often only then that its beneficial influence begins to manifest itself.

In young people mineral-water baths will be found of advantage, and those of Wiesbaden are to be specially recommended. In one case in a child of 5, who had rheumatoid arthritis, beginning in the dorsum of the foot and extending to the elbow joint, a stay at Wiesbaden was followed by great improvement, and she has grown up into a healthy young woman without any trace of joint-disease. A sister of this patient who

was similarly affected has also followed the same treatment with great benefit. The baths, of course, must be supplemented by general treatment continued for a long period.

Age has much to do with the prognosis, for children certainly recover from joint-lesions, which in the middle-aged are most likely to persist and spread until serious crippling results.

Our next case is one of double tubercular apical cavities giving rise to secondary infection of the lung. The patient, a young man of 24, whose family history is in no way suggestive, began to be troubled by cough and expectoration in August, 1898, and though feeling ill he continued his work—except for a sharp attack of pulmonary mischief in March, which confined him to bed for three weeks—until last June, when he had become so weak that he was obliged to remain at home. For the last six months he has been losing weight, and his expectoration, which has persisted since the first symptoms of the disease, contains abundance of bacilli. He is short of breath on exertion, and there is occasional precordial pain.

On examination the case is clearly one of advanced phthisis. There are, or have been, two cavities in the left lung, a primary one at the apex, and a secondary one in the mammary region, but these have now become joined together to form one long sinuous cavity. In the right lung the same process is repeating itself, as there is an apical cavity and a secondary one beginning to form in the axillary region. The case is a good example of secondary cavity formation and the prognosis is most unfavourable.

Our last case is an interesting illustration of the coincidence which occasionally occurs between pulmonary tuberculosis and local injury. The patient, an old man of 70, says that two years ago he was knocked down by an omnibus and his right shoulder much injured, though no bones were broken. He was in bed for a month in consequence, during which time he expectorated blood a number of times—once or twice in considerable quantities. This, however, gradually diminished, and at the end of three months stopped.

Shortly after this a cough, with expectoration of whitish mucus, began, and has persisted ever since; the sputum containing considerable amounts of blood at intervals. His shoulder is apparently ankylosed,

the muscles around greatly wasted, and his arm stiff, but he moves the forearm freely.

There is a well-defined cavity in the upper lobe of his right lung, and both lungs are generally emphysematous.

There is no apparent disease of the heart, but his arteries are atheromatous.

Injuries to the chest-wall may occasionally be followed by phthisis. Some years ago I had under my observation the mate of a merchant vessel, who had had a fall from the mast to the deck, resulting in the fracture of three ribs, followed by the rapid development of well-marked symptoms and physical signs of phthisis, hæmorrhage, expectoration, and cavity upon the injured side of the chest. He, however, made a rapid recovery and returned to his occupation.

In another case—related to me by Dr. Pike—a gentleman was thrown in the hunting field and several ribs severely injured. This was followed by an acute miliary tuberculosis, which proved rapidly fatal.

In all of these cases the connection between the injury and the tuberculosis was probably that the depression and weakening resulting from the shock, prolonged confinement, &c., either lighted up into full activity a pre-existing focus of tubercular disease, or weakened the general powers of resistance so as to permit a new invasion of the system.

As a rule the lung is very little affected in even severe external injuries, the brunt of which fall chiefly upon the pleura, and the chief effect of traumatism upon the lung is by the weakening influence of subsequent illness, predisposing it to tubercular disease.

In the present case the indication is to check the hæmorrhage. There is evidently an old aneurism of a branch of the pulmonary artery or an erosion of a vessel. The leakage is stopped by clots, which tear away from time to time, and hence the fresh onsets of bleeding. As is often the case the patient feels better, and even experiences a sense of relief after each hæmorrhage.

This is not a case in which we could expect much benefit from the open-air treatment, the lesions being too far advanced. The best results of this method are obtained in cases where there is fever and the lesions are not very extensive. Here the effects are most

striking; within a week or 10 days a temperature of 102° to 103° , which nothing else would reduce in the least, begins to decline, and rapidly becomes normal, and there is corresponding improvement in all other respects. In properly selected cases the results are astonishing, and the amount of exposure to the open air which this class of cases will stand is equally surprising. Even the chilliest patients will keep perfectly comfortable all day long lying out of doors with the temperature at zero, or even below, at Davos and the other winter resorts, providing they are well wrapped up and kept in the recumbent position. If they are allowed to sit up there may be the greatest difficulty in keeping them warm, no matter how heavily wrapped up, but lying down there is surprisingly little trouble. All the Continental sanatoria insist upon this point, only allowing just sufficient change of position to guard against interference with free expectoration and formation of secondary foci by regurgitation of sputum into bronchial tubes leading to healthy lobules.

The North Transvaal District.—In the most northerly part of the Transvaal are the Zoutpansberg mountains, and south of them 23° to 24° is the Zoutpansberg district. In this district are many goldfields, and it is likely to become more and more important to goldseeking colonists. Zoutpansberg is a primitive Dutch town (see *Journal, R.G.S.*, 1862). A description of this district by Mr. F. Jeppe will be found in the *Geographical Society's Journal* for September, 1893, together with an excellent map. The unhealthiness of the climate is admitted, and the season 1894 is stated to have been particularly bad as regards fever. The author adds :—"Fever has, however, not been confined to the Zoutpansberg district only. On the railway works in the Elands Valley and near Barberton, fever has been exceptionally virulent, taking away people in the prime of life, and causing great distress. At one mine (Klein Letaba) it was reported that not a single man except the manager had escaped an attack of fever, more or less severe, yet the "men were in capital spirits, and, although mining in the tropics, did not present the washed-out appearance of Anglo-Indians." Mr. Jeppe's map, the most detailed yet published, may be consulted in the Polyclinic Library.

ON CASES OF INHERITED SYPHILIS IN ADULTS WITH EXCEPTIONAL FEATURES.

BY JONATHAN HUTCHINSON, LL.D., F.R.S.

GENTLEMEN,—We are indebted to Mr. Waren Tay for the opportunity for seeing the patient who has just left us, and who was sent from the Moorfields Ophthalmic Hospital. She was, as you saw, a tall, well-grown young woman, yet her physiognomy bore the most unmistakable evidences of inherited syphilis. We will note the fact that the taint does not always hinder development. The bridge of her nose was sunken, her forehead squared with frontal bumps, and the scars around her mouth almost equalled what we sometimes see depicted in books; her skin was thick and muddy. Yet, in spite of these drawbacks from her beauty, she might, if need were, have served as a female policeman, being six feet nine or ten and proportionately stout. The two main features of interest for us, however, were her eyes and her teeth.

She is passing through an attack of most acute keratitis in her right eye, and it is attended by very exceptional conditions. The whole cornea has become very vascular, so that it is everywhere of a dull red or deep salmon tint, and in its centre an hypogion has formed with a superficial ulceration over it. This occurrence of suppurative inflammation as a complication of interstitial keratitis is very unusual. I have seen it before, but only in very few cases. There is another feature of peculiarity in the case as regards the keratitis. It is that one eye has got well before the other was attacked. The left eye went through, as the notes show us, an ordinary attack of keratitis, by no means very severe, in July last and the following months, but the right, which is now so severely inflamed, did not begin till November. As we have seen, the right is now bright and well; the left, it is much to be feared, is lost. This occurrence of a long interval between the attacks in the two eyes is not usual; more ordinarily the second eye follows the first in a few weeks or a month or two at latest, and as the attack usually is prolonged over six months, both are during the greater part of the time affected together. I have noticed sometimes, when this want of contemporaneity in the attacks in the eyes has occurred, or when one eye has

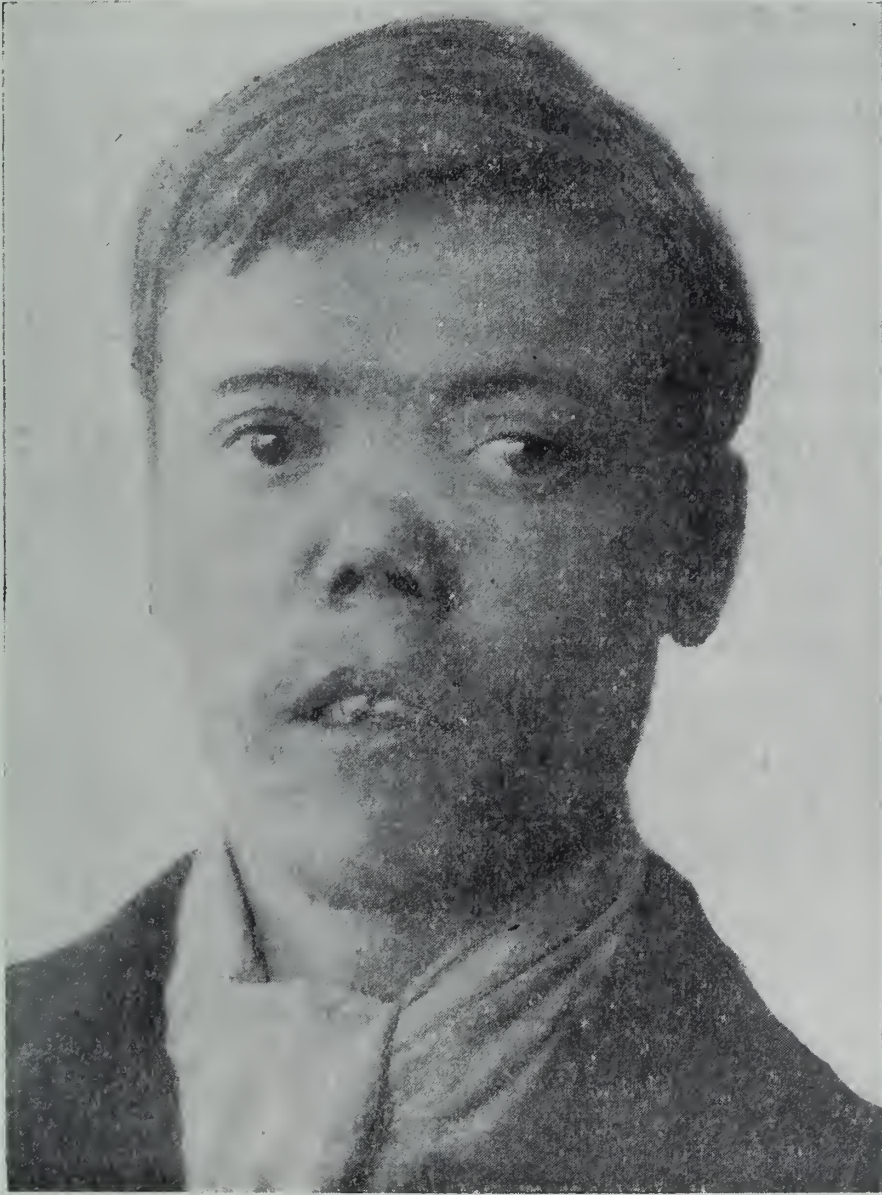
suffered and the other escaped, that there was also a want of symmetry in the malformation of the teeth, suggesting that the two halves of the head had not been developed with precisely the same tendencies to disease. This may have been the case here, for only one of the upper incisors is a typically syphilitic tooth. The other is very much broken, but I do not think it ever was a characteristic one. It had been carious, and she told us that she had broken it in biting a bread crust. Now the syphilitic incisors are usually short and strong, and not prone to caries. The remaining upper central incisor is, as I have said, a characteristic tooth; short, dwarfed in all dimensions, and showing a single broad but shallow notch.

Whilst the woman was before us I asked you to observe carefully the state of her other teeth. No case could have better proved what I have so often asserted, that syphilis of itself, even when severe, does not damage the whole set, but causes malformation of the upper central incisors only. The defects in the other teeth, so constantly seen in association with inherited syphilis, are due not to that disease but to the mercury given in infancy for its cure. Now I venture to assert, with much confidence, that the patient whom we have had before us did not have mercury in her infancy. I make this assertion on the strength of the fact that her other teeth are in good condition, for the most part sound white teeth with good enamel. Now a course of mercury in infancy interferes with the formation of enamel in certain of the teeth, those, namely, which at the period of the treatment are just perfecting their development. It does not hurt the bicuspid, for they are later than most of the others, and not yet susceptible of damage. It causes, however, horizontal furrows across all the incisors and near the apex of the canine, and it bares the surface of the crown of the first molar. It is this last-mentioned, "the six-year molar"—one of the first to appear of the permanent set, and perhaps the earliest to complete its calcification—which is the most prone to be injured. Now in the woman whom we have just seen, as I pointed out, her first molars, those which remain of them, are sound white teeth, the enamel being complete over the whole of their surfaces. Such molars are, I submit, never seen in those who have taken mercury in infancy.

We have in this case no history to help us. The patient is a young woman of 22, and we have no facts as to her infancy. We only know that she is, as usual, the oldest living of a small family. The statements

which I have made are, however, based upon the observation of many cases in which I have had clear histories.

Having dismissed our present patient, I purpose, Gentlemen, if you will allow me, to pass in review a series of cases the subjects of which we have had before us on various occasions during the last six months.



I cannot again produce the patients, but as their narratives all bear upon the same topic, I think it may be useful that we should recapitulate them in group—the general topic being the recognition of inherited syphilis in those who have arrived at adult age, and the kind of maladies to which at that period they are liable. We have had before us some most important and instructive cases bearing upon these matters. Repeatedly we have been obliged to admit that this diagnosis is by no

means always an easy matter, and that, however valuable deformities of the teeth and peculiarities of the physiognomy may be, they often, on account of their entire absence, fail to render us any help.

The first case that I will remind you of is that of the young man whose portrait I now show you. In him the physiognomy and the teeth were well marked, his nose being more than usually sunken. His septum was partly destroyed, and so also was his uvula, and his soft palate had, as a consequence of ulceration, contracted adhesions to the pharynx. His irides were of steel-grey hue, and his pupils small. He had been through an attack of keratitis. I cannot tell you anything about his family history, but the evidence will probably be deemed conclusive without it. Now, the affection for which he was sent to us was a somewhat unusual one in connection with inherited taint. Both his femora, but especially the right, were much enlarged by chronic periostitis in their lower halves. The condition was that of general fusiform enlargement, coming very nearly to the knee-joint, and shading off gradually above the middle of the bone. There was present also some slight thickening of the tibiæ, and here again it was chiefly on the right side. Now periostitis, with the result of osseous nodes, is common enough in the childhood of those who suffer from inherited taint, but the tendency to it usually ceases about puberty, whereas our patient is 28, and it appears to be aggressive. Nor is the femur often affected at any age. It is, however, almost always the lower half of the bone which is affected, as in this case.

(*To be continued.*)

Hottentot Kraals.—"In Pugen, the chief town, there are several cattle kraals; the principal one, a well-built oval, 93 yards in diameter between its axes. The wall is of dry stones, fully 4 feet in thickness, of equal height, and as well built as if the work of a European mason. Altogether, the cleanliness pervading these native kraals is such as ought to shame the Dutch Boers."—Sanderson, 1851, *R.G.S.*, vol. xxx.

The Penny Cyclopædia (1836) says:—"The fisheries of Cape Colony form an important branch of industry in those districts which are on the coast. The fishery is carried on in boats of from two to seven tons each; about 50 such boats are employed in Table Bay alone. Every settler whose farm is on the sea coast keeps a fishing boat for the supply of his own family."

In 1874 Cape Colony exported nearly 5,000,000 lbs. of cured fish valued at nearly £35,000 (= 1½d. a lb.).

DR. MANSON'S LECTURES ON MALARIA.

THE two lectures by Dr. Patrick Manson upon "Malaria and the Malarial Parasite," delivered at the College, were an admirable summing up of our knowledge upon this most important subject. They were abundantly illustrated by both microscopic specimens and by drawings, which were greatly appreciated by the large attendance of members present.

One of the most interesting features was the graphic description of the gradual passage of the malarial parasite through the tissues of the mosquito. Beginning in the stomach as a flagellate organism sucked up in the infected blood, imbedding itself in the stomach wall as the round pigmented body, working its way through the successive coats of the viscus until it comes to lie under the outer layer, and finally to bulge into the body cavity. By this time its bulk has so greatly increased by the repeated fragmentation of its nucleus and consequent enlargement of its contents, that it has become converted practically into a huge spore-bag full of little rod-like spores. The outer membrane ruptures, and the spores are set free in the tissues, to find their way ultimately, in some curious manner, into the salivary or venom glands. Here they crowd the acini in myriads, waiting, with apparent intentionality almost, their opportunity to be discharged into the blood of the next human being bitten, there to begin anew the cycle of their development.

This singular travelling of the spores through the body of their host toward the one region and organ where they will be afforded an opportunity of transfer to the new surroundings which are absolutely necessary for their further development, strikes the non-expert as one of the most remarkable things in their strange life-history. The length of time which it must have taken for the formation of the habit baffles conception.

Someone, it may be added, has suggested that the piling up of the tubercle bacilli in the mammalian lung is due to this same sort of blind tendency to drift toward and accumulate in that region of the body of their host from which they can be most readily transferred to new fields of development outside of the body; but this would involve at least a degree of motility on the part of the bacillus which is not one of its recognised characters.

Most clear and lucid was Dr. Manson's description of the characters by which the true malaria-bearing mosquito, *Anopheles*, can be distinguished, even by the non-expert eye, from the harmless *Culex*. Their mere position when at rest is fortunately sufficient. *Anopheles*, when resting upon the wall of a room, for instance, during the daytime, carries its body almost at right angles to the surface upon which it sits, spike-fashion, like a nail driven into the wall. *Culex*, on the contrary, carries its body parallel to the surface on which it rests. So that the two species can be distinguished at a glance when at rest.

Next, upon closer inspection, the length of the proboscis and palpi in *Anopheles* will be found almost equal, while in *Culex* the former is much the longer.

Finally, in hunting the pools for the larvæ, those of *Culex* will be found floating head downward, while those of *Anopheles* float horizontally upon the surface.

Fortunately the dangerous form is only about a tenth as common as the harmless one, and so fastidious is it in the choice of its breeding pools, that these may only number a dozen or so in an entire neighbourhood; so that the lecturer was quite sanguine as to the possibility of their complete draining, or poisoning with kerosene, and the extermination of malaria in a given district by this means. The requisites of an *Anopheles* pool are that it must be permanent, or at least exist during the greater part of the year, while *Culex* will breed in any rain-puddle or water-butt. It must be free from minnows, or from communication with pools or streams containing them, as these feed greedily upon the larvæ, and there must be an abundant growth of algæ as food for the larvæ. These numerous requirements are at least part of the explanation of the comparative rarity of the pools, and, consequently, of the adult insects.

Most definite and hopeful were Dr. Manson's views upon the practical value and therapeutic outlook of the discovery of the parasite and its habits. The secret of the pathology of malaria lies in the reaction of the system to the germ. Diagnosis is made absolutely accurate, and treatment equally definite and certain. The malaria-parasite can be poisoned by quinine as certainly as a man can by arsenic. The microscope has become the stethoscope of the tropics, and is even more indispensable to competent practice. The physician who attempts to practice in the tropics without it is guilty of almost criminal neglect.

Once the parasite is discovered we are masters of the situation, as quinine will cure 99 per cent. of genuine cases, if it can be introduced and absorbed in time.

Koch's statement as to the production of black-water fever by quinine he regarded as most unfortunate, on account of the misunderstandings and distrust of our chief remedy to which it had given rise. While it was true that quinine had a tendency, in some instances, to precipitate an attack, yet it was not nearly so active in this respect as the malarial parasite. Hence, when the latter was present, quinine should by all means be given, as it would avert a far greater danger by its parasiticide action than could possibly be incurred by its own effects upon the blood. Herein lies the value of an accurate diagnosis by the microscope, for as the establishment of hæmoglobinuria is fortunately often accompanied by the destruction of the parasite and its rapid disappearance from the blood, whenever the parasite is not found present we may safely withhold quinine, and thus avoid the risk referred to by Koch.

In all other forms of the disease the drug was a specific and absolutely indispensable, all the other remedies recommended having proved of little value, except as adjuvants or last resorts in cases where the patient's idiosyncrasy will not permit the use of quinine.

The ultimate hope is of the complete extermination of the disease by the destruction of its sole conveyors, and by this means removing the greatest bar to the colonisation of the tropics by the white races. Climate, as an obstacle, is as nothing compared with malaria, which ought soon to be ranked as a preventible disease.

DIPHTHERIA AND OTHER DISEASES IN THE TRANSVAAL 50 YEARS AGO.—“Many of these natives (Magaliesberg) I observed marked with the small-pox, a disease not now prevalent amongst them, as Mahata told me, but formerly both common and fatal.

“The Pillans'berg also lies to the north-west, and was said to have been lately entirely depopulated by some fatal epidemic among the natives.

“There is also a total absence of qualified medical practitioners. A new disorder had been very fatal lately; it was known as the “keel-pok,” or “throat-pox,” and from description I should think was a kind of ulcerated or putrid sore throat. During my visit to the Magaliesberg, and as I was leaving, I heard a great deal of a very fatal fever prevalent on the Marikwa River to the westward.”—Sanderson, 1851, *R.G.S.*, vol. xxx.

James Backhouse (1840) records having been asked to prescribe for a very fat Boer child in a travelling wagon, which appeared to be dying of croup.

ABSTRACT OF A LECTURE ON NON-DIABETIC GLYCOSURIA.

BY ROBERT SAUNDBY, M.D., LL.D., F.R.C.P.

(Delivered at the Polyclinic, March 14th, 1900.)

EVERY practitioner who follows the routine practice of examining the urine for sugar meets from time to time with cases where in the absence of any symptoms of diabetes the urine reduces copper. This may be due to some reducing substances other than sugar, but such cases of pseudo-glycosuria can be distinguished by filtering the urine repeatedly through animal charcoal before employing the copper test. Of the cases of true glycosuria some may be met with in persons who present no other indication of ill-health, and who believe themselves to be quite well. These are generally found among applicants for life insurance, of which five illustrative cases were briefly related. It was suggested that at least some of these cases may be due to alimentary or physiological glycosuria, that is to say, to the patient having an abnormally low capacity for assimilating sugar, so that the surplus escapes in the urine. In one of the cases related the glycosuria had persisted for 13 years without producing any obvious effect upon the general health, although the patient was when first seen a man aged 32.

Of the cases of pathological glycosuria no fewer than 22 were associated with some obvious derangement of the alimentary system, and in eight of them there was more or less complete evidence of alcohol as a primary cause, while in some of the others, who presented chronic gastric or hepatic troubles, it was impossible to avoid the suspicion of alcoholic abuse. A number of illustrative cases were quoted, as the lecturer desired to insist particularly upon the influence of alcohol as a cause of glycosuria.

Eight cases of glycosuria associated with various manifestations of the gouty diathesis were mentioned, but the subject was considered to be sufficiently well known to dispense with illustrations, as were also those forms due to infective processes, to staphylococci, to injuries, and to malignant disease.

A case was related where the glycosuria of lactation had been mistaken for diabetes with somewhat unfortunate results. The

dependence of glycosuria upon neurasthenia was illustrated by cases in which the urine became normal when the general health had been improved by properly directed treatment.

Finally, the lecturer drew attention to cases of senile glycosuria in old persons who present other signs of general decay.

One of the cases of alcoholic glycosuria reported was of striking character, from the fact that the presence of sugar was suspected from the history of the case before any tests were made, and that it promptly disappeared on the removal of its cause.

The patient was a civil engineer who had lost his position and ruined his health by excessive drinking. When brought to the hospital he was in a state of utter nervous breakdown, with tremors and unsteady gait, and talking of suicide. Glycosuria was suspected, and found on testing. He was received into the ward, put to bed, and well fed, his supply of alcohol cut off, and in a short time the sugar completely disappeared from his urine *pari passu* with the improvement of his nervous symptoms.

Another interesting statement was that of the exact sugar-capacity of the average human body, or the amount of grape-sugar which can be introduced into the stomach without "overflowing" in the urine. This varies widely in different individuals, ranging from 9 to 17 ounces, administered within a few hours. It was at one time asserted that those individuals who had a low normal sugar-capacity, and developed glycosuria after comparatively small doses of grape-sugar, were especially apt to become diabetic, but this has not been confirmed by further observation.

An older suggestion of Cheselden's, as to the relation between carbuncles and furuncles and glycosuria being sometimes the reverse of that formerly accepted, had, however, been recently confirmed, in that injections of pure cultures of staphylococci into the blood of dogs had been followed quite constantly by marked glycosuria.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

OPHTHALMOLOGICAL CASES.

BY HOLMES SPICER, F.R.C.S.

CASE I.—*Iridectomy for Release of Incarcerated Iris.*

A BOY of 12, eight years ago had severe ulceration of both corneæ, resulting, in the left eye, in a large perforation. The centre of the cornea is now occupied by a dense leucoma, and nearly half the margin of the pupil has been involved in the scar. In the right eye there is merely a central facet-like scar. As the vision of the left eye was reduced to bare ability to count fingers, and there was some threatening of increase of tension and tenderness, an iridectomy was decided upon. Two months ago a considerable segment of the iris was removed to the inner side of the leucoma, so as to give an artificial pupil opposite a clear portion of the cornea. This has relieved the tension, brought the vision up to six-thirty-sixths, and avoided a possible risk of glaucoma. Later it is proposed to tatoo the leucoma, and still further improve vision by getting rid of “dazzling” effect of the white scar.

CASE II.—*Acute Stage of Interstitial Keratitis.*

A boy of 10 was presented with an acutely inflamed condition of the left eye. There was slight puffiness of the lids and conjunctiva, and marked photophobia. Upon separating the lids the whole mesh of subconjunctival vessels were seen to be congested, and especially in circumcorneal zone. No trace of ulceration or localised lesion of the cornea is to be seen, but the whole extent of its substance has a “steamy” look, and the iris looks dull and muddy. As, however, it moves freely in response to light, and there are no adhesions or apastus in the anterior chamber, its dull appearance is probably due solely to the condition of the cornea. The case is one of interstitial keratitis, probably of specific origin, although the history is not altogether conclusive, and its chief interest lies in the fact of its recognition in such an early stage, before the development of the “salmon patch”

or other more characteristic signs. The treatment is of course mainly constitutional, grey powder and iodide of iron, with sedative local applications.

DERMATOLOGICAL CASES.

BY MR. MALCOLM MORRIS.

Eczema attacking the Areas of Alopecia Arcata.

THE patient, a boy of 8, has had alopecia areata for three years past. A large part of the scalp is still completely denuded, with very little tendency yet showing to any fresh growth of hair. By a strange exception to the usual rule of immunity from all inflammatory reaction upon the part of these pale, shining, bloodless areas, a profuse pustular eruption, with thick honeycomb-like crusts, broke out some weeks ago upon the denuded portions of the scalp. This has spread to the regions still covered by hair and proved most obstinate and annoying. It is largely confined to the posterior half of the calvarium behind the middle of the temporal ridges. Usually, of course, these alopecia patches will tolerate the most stimulating and even irritating applications without much inflammatory reaction, indeed, the great difficulty is to arouse a response of any sort upon the part of the atrophied skin. This eruption cannot be traced to any irritant local application.

The condition suggests the possibility of the case being one of Tinea tonsurans, with some local septic infection superposed, as there is a history of eczema of the scalp previous to the alopecia. But against this is the fact that repeated examinations of the root-sheaths has been made all through his alopecia and not a trace of fungus discovered. Moreover, there is no history of possible infection or of spread to other members of the family. This makes the case of peculiar interest as a representative of a class which we often meet. Cases of patchy baldness occurring singly or in groups of 10 or 12 simultaneously in schools, or perhaps a few cases developing each successive term, and yet not a trace of fungus or clinical history of ringworm is to be discovered.

BY T. COLCOTT FOX, M.D.

Mycosis Fungoides in the Early Stage.

ALL over the surface of the chest, arms, and back of a woman of 32 are scattered patches and areas of dull red, slightly elevated eruption. The more recent patches are pinkish-red, scaly, and with rather definite margins, so as to be scarcely distinguishable from some form of eczema seborrheicum or the irritation following the bites of insects, but as they persist they show a steady tendency to run together to form larger patterned areas, and these become elevated and finally tuberculated at their edges; then, by the breaking down of these marginal elevations or small tumours, ulceration is set up, and the characteristic type of the disease is shown.

This case has only reached the stage of a distinctly elevated and bossy margin around some of the patches, but as the condition has lasted 15 months, and is slowly but steadily progressing in spite of treatment, there is little doubt as to its real character.

Drawings were shown of cases in a slightly more advanced stage, and of the macular stage of leprosy, illustrating the possibilities of confusing the two conditions.

BY ARTHUR WHITFIELD, M.D.

CASE I.—*Superficial Tubercular Syphilide of Breast.*

MRS. L. H., aged 44, was presented, showing a ring-like patch of scabbing with an elevated margin upon the right breast. The patch is of about the size of the palm, is clearing up in the centre, and extends over the front of the sternum.

The first trace of the disease was in the form of scattered pimples, which appeared some four months ago. Its centre is occupied by a thin flat scar, which, with its elevated and aggressive margin, gives it a decidedly lupoid appearance. The diagnosis lies between lupus, Paget's disease, and syphilis.

The central scar is too sound and free from nodules for lupus, in which the resulting scar will nearly always show, on close inspection, tiny spots of "apple jelly." The course has been too rapid for Paget's disease, which would have taken 10 or 15 years to cover an area of this

size. As the patient has no living children, her first having been born dead and her second surviving only six weeks after birth, the case is almost certainly one of what used to be termed "syphitic lupus," but which is now designated serpiginous cutaneous gumma. The patch has greatly improved already under the use of the oleate of mercury locally and the biniodide internally.

The patient also has complete ptosis of the right lid, which she insists on attributing to an operation for the removal of a small sub-cutaneous tumour just in front of the ear. This she declares "cut the nerve and let the lid drop." As, however, the pupil is dilated and immobile, and the movements of the eye in all directions defective, it is clearly a case of ophthalmoplegia of syphilitic origin.

CASE II.—*Syphilitic Eruption mimicking Psoriasis.*

As a companion to the above a woman, aged 50, was shown with a large ringed patch of scaly eruption upon the calf of the right leg. The patch was to the eye one of absolutely typical psoriasis, gently elevated, clearly margined, bossy, and covered with coating of silvery scales. The condition can, however, be anatomically distinguished from psoriasis by the absence of oozing a slight bleeding when adherent scales are scraped away. This oozing in true psoriasis is due to the cornification of the epidermis extending down to the rete mucosum and tips of the swollen papillæ, leaving the former exposed when the scale is lifted. The distribution of the lesions is also atypical, they have begun too late in life, and there is clear history of syphilis.

CASE III.—*Ringworm of the Nails.*

Mrs. M., aged 53, presented herself on account of a most disfiguring condition of her finger nails. These are blackened, broken, and horny looking, with a curious deep dish-like depression across the centre of most of them. The disease began upon the right thumb nail six months ago, and gradually spread until now all the nails on both hands are affected with the exception of the right ring-finger and both little fingers. The nail-fold and base of the nail are the chief site of attack, and the whole thickness of the matrix has become affected, causing cracking and roughening of the surface which looks as if covered with crusts of baked mud. The fore edge of the nail is

completely broken away. No fungus can be found in the nail-tissues, though repeated examinations have been made, but this may be almost said to be the rule in these nail cases, even where there is evident ringworm elsewhere upon the body. It is at least extremely scanty, and probably assumes the endothrix form, and infests only the deeper tissues of the matrix and nail-base, from which regions it is almost impossible to get scrapings for examination on account of their extreme sensitiveness and tenderness.

The most effective treatment is by wrapping with shreds of lint dipped in a weak solution of iodine and iodide of potassium, which improves most cases rapidly, but has proved too irritating here, causing both pain and inflammation. Softening by caustic potash and scraping, followed by bichloride dressings, will be tried, but the ultimate resort will probably be complete removal of nails under anæsthesia. An interesting feature of the history is that the disease began upon the thumb directly after an injury to the nail, which possibly permitted the entry of the fungus.

BY JAMES GALLOWAY, M.D., F.R.C.P.

CASE I.—*Keloid in the Scar of Lupus.*

THE patient, Mrs. W., aged 38, has been annoyed by a small patch of chronic lupus vulgaris upon the right side of the neck, just below the ear, for 15 years past. As it had resisted all other treatment, two years ago she submitted to a scraping operation, and the patch was thoroughly destroyed by erosion. A smooth, clean, healthy scar resulted, and for some months the cure appeared to be complete.

The disease soon recurred, however, and was next attacked by the thermocautery. Again relief was only temporary after the first removal, but a second and third were more successful. The lupus completely disappeared, but keloid overgrowth developed in the resulting scar.

This now forms almost as great a disfigurement as the lupus patch which it replaces, as the keloid mass is nearly three inches long and half an inch in thickness, much the size and shape of the little finger. Its colour is distinctly pinker than that of the surrounding skin, but it is firm and incompressible, though elastic. Dr. Galloway had been keeping the growth under observation for some time, in the hope that

it might prove to be mere cicatricial overgrowth of inflammatory character, and gradually shrink of its own accord. As, however, much to his disappointment, it had continued to increase in prominence, he proposed to attempt its reduction by multiple punctures with the electrolytic needle.

The chief interest of the case, apart from its unusualness, lay in the clear and definite manner in which its history supported the theory of the dependence of keloid upon pre-existing scar-tissue. It is not often that the connection can be so directly traced, and the apparent influence of repeated irritation as a factor so clearly seen.

CASE II.—*Elephantiasis of the Right Leg.*

The patient, who is an engineer, 75 years of age, has been annoyed by great thickening of the right ankle and leg to a little above the swell of the calf for 25 years past. Of late its weight, and the offensive character of the discharge from the inflamed surface, has completely disabled him, so that for a time he had to give up work entirely. When he was first seen, some months ago, the surface of the tensely-swollen brawny leg was covered with a network of cracks and fissures, between which were islands of warty growths, the oozing and discharge from all of which were most offensive, and covered the whole surface with a decomposing layer. This was seriously threatening to affect the entire system by septic absorption. His general health is excellent, and he looks 10 years younger than his real age. There is no history of any significance. The thickening began in the skin of the foot and ankle, and has gradually spread upward to present level, but the thigh is unaffected, and there appears no appreciable enlargement of the lymph trunks or along the veins.

Under careful cleansings, and the free use of salicylic acid as a dusting powder, the fissures have healed, the more prominent warts disappeared, and the septic condition had been completely relieved, so that he has been able to return to work.

The present appearance of the skin is most peculiar, in patches suggesting ichthyosis, the whole epiderm being covered with a dense layer of warty growths of a bluish-black colour. The surface of these growths is, however, comparatively smooth and level, as if "planed down" by some erosive agency, giving the skin a decidedly shagreen-like appearance. In some parts of the surface the "planing down"

appears to have worn away the warty elevations entirely, leaving a smooth, semi-translucent thickening of a bluish tint, resembling some forms of scleroderma.

COLEY'S FLUID IN MYCOSIS FUNGOIDES.

AN interesting therapeutic experiment is being carried out by Dr. Galloway upon a case of well-developed mycosis fungoides, presented for him by Dr. Colcott Fox as reported in our last issue.

The similarity of the disease to sarcoma has long been noted by many observers, and was specially commented upon by Dr. Fox in his demonstration, and as the disease was rapidly reaching a stage where the prospects of either amelioration or cure were almost hopeless. Dr. Galloway resolved to act upon the analogy, and as a last resource to apply the remedy for which such striking results have been claimed in inoperable sarcoma. To this decision he was also encouraged by the marked improvement which had taken place in one reported case of unquestioned mycosis after an accidental attack of erysipelas.

The treatment was begun by the injection under the skin of the thigh, just at the lower border of the largest plaque of the growth, of half a minim of the fluid (the mixed toxins of the streptococcus (pyogenes) of erysipelas and the bacillus prodigiosus). This produced little reaction, so the dose was gradually increased at intervals of two days, until the third injection, when a sharp rise of temperature to 103° occurred, preceded by a rigor, much to the alarm of the patient. Three other injections were given, making six in all, but these latter were followed by but little discomfort or disturbance of the temperature.

When Dr. Galloway reported the case at his consultation on March 5th there was already gratifying improvement apparent. The growth was softening with consequent relief of both the pain and feeling of tension, and the patient felt much more comfortable. The discharge from the fungating surface had diminished and the largest ulcer upon the summit of the growth had healed.

As only about three weeks had then elapsed since the beginning of the treatment, it was far too soon to count upon any permanent result, but the future progress of the case will be watched with much interest and even hopefulness.

DISEASES OF THE NOSE, THROAT, AND EAR.

BY STCLAIR THOMSON, M.D., F.R.C.S.

CASE I.—*Mycotic Invasion of the Tonsils (Pharyngomycosis Leptothricia).*

THIS disease is chiefly of interest from its curious appearance, its mild but extremely obstinate character, and the alarm which it gives rise to through being mistaken for more serious conditions, such as diphtheria or septic tonsillitis. The patient, a man of 26, is a typical case, both as to appearance and history. A number of sharply-defined white patches are readily visible upon his tonsils, but instead of being included in the tissues as the "plugs" of follicular tonsillitis, or spreading over their surface membrane-fashion, they project sharply above the general level like masses of tiny stalactites. Nor are their well-defined bases surrounded by any zone of redness or inflammatory reaction. The patient says that he discovered these upon happening to look into his throat 10 weeks ago, but that before that he had scarcely been aware of anything wrong there, except a slight tickling at times.

This is a typical history, and patients are greatly frightened by the sudden appearance of these diphtheritic-looking patches, but of course there is no difficulty in separating the affection from either follicular tonsillitis, by its extreme chronicity, and from diphtheria by its utter absence of general symptoms. The patches may persist for months and yet give rise to no trouble whatever, except the uneasiness excited by their appearance. Mild as the disease is, it is extremely obstinate, and resists every form of treatment for months and even years. The only effective treatment is curetting, followed by the application of chromic acid. As the leptothrix fungus is a normal inhabitant of the pharynx. Liebermann has suggested that it is merely an accompaniment of the process, which is anatomically a keratosis of the mucous membrane; a piling up of the epithelium in mounds.

CASE II.—*Fibrinous Rhinitis of Diphtheritic Character, but without Constitutional Symptoms.*

A girl of 17 came under observation four weeks ago with her right nostril completely blocked by folds of white false membrane. So large

were these flaps that they gave rise to a first diagnosis of collapsed polypus, but upon seizing one of them with the forceps an almost complete cast of the nasal passages came away. The post-nasal space was coated by a similar membrane. Cultures were sent to the Jenner Institute, and diphtheria bacilli reported present in fair numbers. The patient had a temperature of 100°, a few glands in the neck were slightly enlarged, but she has been well and strong and able to go about all through the attack, her only complaint being of a feeling of lassitude at times. Patches of membrane are still to be seen in both nasal passages, but the obstruction is relieved and the condition slowly improving.

The case is a typical one of a small but well-recognised group, the chief interest of which is that they are bacteriologically diphtheria, without question, as the bacilli taken from them have been found virulent, with an abundant local reaction in the shape of false membrane, and yet neither affect the general system or spread to other members of the family. A number of these cases have now been carefully investigated, and no instance of their proving infectious to others discovered as yet.

CASE III.—*Inflammation of a Persistent Thyreo-glossal Duct.*

A young man of 27 was shown, who sought advice on account of a small dimple-like opening in the skin of his neck, just below the larynx. This was found to be the mouth of a fistula running directly upward towards the hyoid bone, and the patient stated that, when discharging freely, a probe could be passed upward in the median line for some little distance. At present the opening is almost closed, and the discharge reduced to a mere oozing at intervals of a few days, but the lips of the opening are red and swollen, and the condition annoys the patient by its appearance.

An interesting feature of the history of the case was that the trouble first began during convalescence from an attack of typhoid fever four years before. A rounded cord-like swelling formed just under the skin and in front of the larynx, and as it was soft and fluctuating it was lanced by his medical attendant. A free discharge of muco-pus followed, and a permanent sinus resulted; but after some months this seemed to heal, only, however, to begin discharging again after an interval. This

intermittent discharge had continued ever since, although of late it had become little more than a periodic oozing.

CASE IV.—*Furunculosis of the External Auditory Meatus.*

A man was shown in whom the declining stage of this condition was evident. He had hardly slept for three nights before attending the Throat Hospital. The meatus was well syringed and disinfected with 1 in 1000 perchloride of mercury, and a short piece of rubber drainage-tube was then introduced into the external ear and left *in situ*. It was of as large a diameter as could be used, as its good effects were attributed to the compression which it exerted. It was removed daily for antiseptic syringing, and then cleansed and replaced. At the same time the patient's general health was attended to.

Many varieties of treatment have been suggested for furunculosis. Although it was sometimes easy of diagnosis and readily relieved, an ordinary attack of "boils" in this region sometimes gave rise to a clinical complexus, which required great care in diagnosing. Dr. Thomson feared that more than one mastoid had been opened under the impression that there was pus in the antrum, when the only affection was a furunculosis of the external meatus.

This mistake in diagnosis, of course, was apt to occur when the meatus became obstructed and inflammation spread to the neighbouring lymphatic glands. It was sometimes said that if the ear stood out from the side of the head it indicated mastoid mischief, but he thought that this was not always the case, and that it was safer to take the retro-auricular groove as a guide. This was effaced early in furunculosis, whereas it persisted later in mastoiditis. Lymphangitis, swelling and tenderness of the peri-auricular glands was the rule, and occurred early in the former affection; in the latter it was late and exceptional. Indeed, both the pain and the tenderness on manipulating the ear were both much more acute in furunculosis. Any disproportion between the pulse and the temperature was in favour of mastoiditis.

A member referred to the advantage of applying tincture of iodine in the early stage of furunculosis.

BY HERBERT TILLEY, M.D., F.R.C.S.

January 12th, 1900.

CASE I.—*Malignant Disease of Larynx, for which Thyrochondrotomy was performed nearly two years ago.*

THE patient is a man, aged 49, who sought hospital relief for “hoarseness” of six weeks’ duration. Examination of the larynx revealed a whitish-grey nodular thickening occupying the anterior fourth of the left vocal cord.

A slight zone of congestion was noticeable around the growth, and the cord was immobile on phonation. The rest of the larynx was normal, and there were no enlarged glands in the neck. The radical operation was performed, consisting—(1) Of tracheotomy, followed by insertion of Hahn’s canula. (2) Splitting of the thyroid cartilage in the middle line and excision of the cord by means of scalpel and scissors. In carrying out this the ventricular band was also removed, so that the inside of the left thyroid cartilage was laid bare. (3) The two halves of the thyroid cartilage were then sutured in the mid line, and also the rest of the superficial wound. The patient made an uninterrupted recovery, and is now in perfect health, nearly two years after the operation.

The interesting features in the case were:—(1) That “hoarseness” was the only symptom indicative of the presence of so grave a disease. (2) The efficiency of the radical operation, which essentially consists of many important details. (3) The excellent voice which the patient retains in spite of the absence of one vocal cord, the place of which is taken by a band of cicatrising tissue.

CASE II.—*A Patient in whom Empyema of the Maxillary Antra on both sides and the Ethmoidal Cells and Frontal Sinus on the left side had been present, but were ultimately Cured by Radical Operations.*

The patient was a woman, aged 39, who complained of nasal obstruction, severe frontal headaches, and an unpleasant discharge into the throat. The symptoms had continued for three or four years. On examination both nostrils were found occluded with polypi and bathed in foul pus.

In the course of two or three sittings these were removed. The

antrum was explored by Lichtwitz's trochar and found to be full of pus. A silver-wire alveolar drain was inserted, but very little relief accrued from the daily irrigation with antiseptic lotions, which was carried out for three or four weeks. The antrum (left) was then opened in the canine fossa and found to be full of the polypoid degenerations of the mucous membrane. These morbid growths were curetted away, a large opening made into the nose in the inferior meatus, and the antral cavity plugged for 48 hours. It was then syringed out through the naso-antral opening for a month, but still the discharge continued. It was therefore fairly evident that a higher sinus was suppurating. The anterior half of the middle turbinate was next removed, the middle meatus cleared of polypi and granulations, and ultimately the frontal sinus was opened from the outside. It contained pus and large polypoid granulations which were removed, a large opening made into the nose and drain tube inserted, after which the external wound was sutured. The maxillary antrum was similarly treated on the right side. The patient has been quite relieved of her troubles, and in spite of the numerous surgical interventions she considers her present relief worth all she went through. Dr. Tilley pointed out the importance of recognising that a purulent discharge in the middle meatus nearly always indicates accessory sinus suppuration, antral, ethmoidal, or frontal.

That such discharges may be accompanied by severe headaches, which may be the only symptom complained of, and that after fair trial with antiseptic irrigation of the antrum or frontal sinus, the only prospect of a cure lay in the performance of some of the more radical operations.

CASE III.

A woman, aged 29, with tertiary syphilitic eruption of the skin of the upper lip, offensive purulent nasal discharge, perforation of the hard palate, through which bare bone could be felt.

The nature of the case was obvious. There had been a gummatous infiltration of the mucous membrane, covering the vomer, which was now breaking down, and hence the offensive sanious discharge. The patient was doing remarkably well under iodide of potash and mercury. The value of inunctions of mercury ointment in nasal syphilis was dwelt upon. The patient was cleansing the nostrils twice daily with an alkaline antiseptic wash.

CASES AND COMMENTS FROM THE SURGICAL CLINIC.

BY JONATHAN HUTCHINSON, LL.D., F.R.S.

(Continued from p. 126.)

VIII.—*Curvature of Spine caused by Carrying a Child exclusively on One Arm.*

THE case of aggravated scoliosis depicted below was of much interest, on account of the lesson which it conveyed as to a common cause of

Portrait of Back of Patient. (*From a Photograph.*)

this deformity. Its subject, a girl of 15, of very poor parents, had for practical purposes only one arm, and she had been compelled from early childhood to carry a baby about. It was on her left arm only that she could rest the child, and the result had been that the spine had been bent over with the convexity to the right. The deformity was extreme, bringing the left lower ribs below the iliac crest, and

causing great loss of stature. The upper limbs were congenitally malformed, and the right useless.

I remarked that the case was only an extreme example of what, in less degrees, is not uncommon, and said that it was well recognised that lateral curvatures of the spine were often produced in growing girls by the unbalanced employment of one upper extremity.

IX.—*Ivory Exostoses from the Ethmoid Bones (Symmetrical).*

We have had repeatedly under observation, through the kindness of one of our members, a man in whom a most singular deformity of the face is produced by the growth of exostoses in the nares. The woodcut



Portrait showing the Symmetrical Bulging on each Side of the Nose of Ivory Exostoses, which entirely Blocked the Nostrils.

here given is not taken from his photograph, but is so exactly like him that it may serve as well as if it was. The two cases are in all features alike. The patient whose photograph is here copied was under my care nearly 30 years ago, and at that time I had a third under observation. These three cases constitute the sum of my experience of the condition in its most typical form. In all three the nares were blocked by what felt like rounded masses of hard bone, which, pushing outwards the nasal bones, bulged prominently towards the cheeks. Everywhere the bulging bone is hard and rounded, and my diagnosis is that it consists of ivory exostosis springing from the ethmoid. The growths in all

three cases have been symmetrical, and a very peculiar appearance is given to the physiognomy by the way in which the lower part of the nose is buried between the rounded masses.

I showed, in connection with this case, a skull in which an exostosis

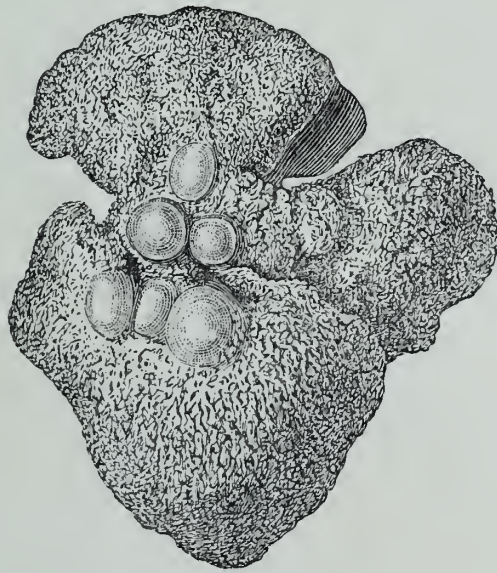


Portions of a Large Ivory Exostosis which was Removed from the Orbit of an Adult Woman.

growing from the ethmoid filled up the upper part of the nose and bulged into the orbit. In that case, however, the lesion was one-sided only. In demonstration of the fact that large exostoses of ivory hardness might be produced from the thin bones of the nose and orbit

I showed several sketches. In one the growth was formed in the frontal sinus, and in another, in which it attained the size of a fist, it grew from the apex of the orbit.

We discussed the question of operative treatment in our present case, but decided against it, feeling sure that it could not be accomplished without danger, and having regard to the fact that the growths did not cause much inconvenience. I assured the patient that they were not likely to grow any larger, since it is a law with most exostoses that they grow during the growth of the body, and cease to do so when full development has been attained.



Ivory Exostosis Removed from the Frontal Sinus of a Young Man.

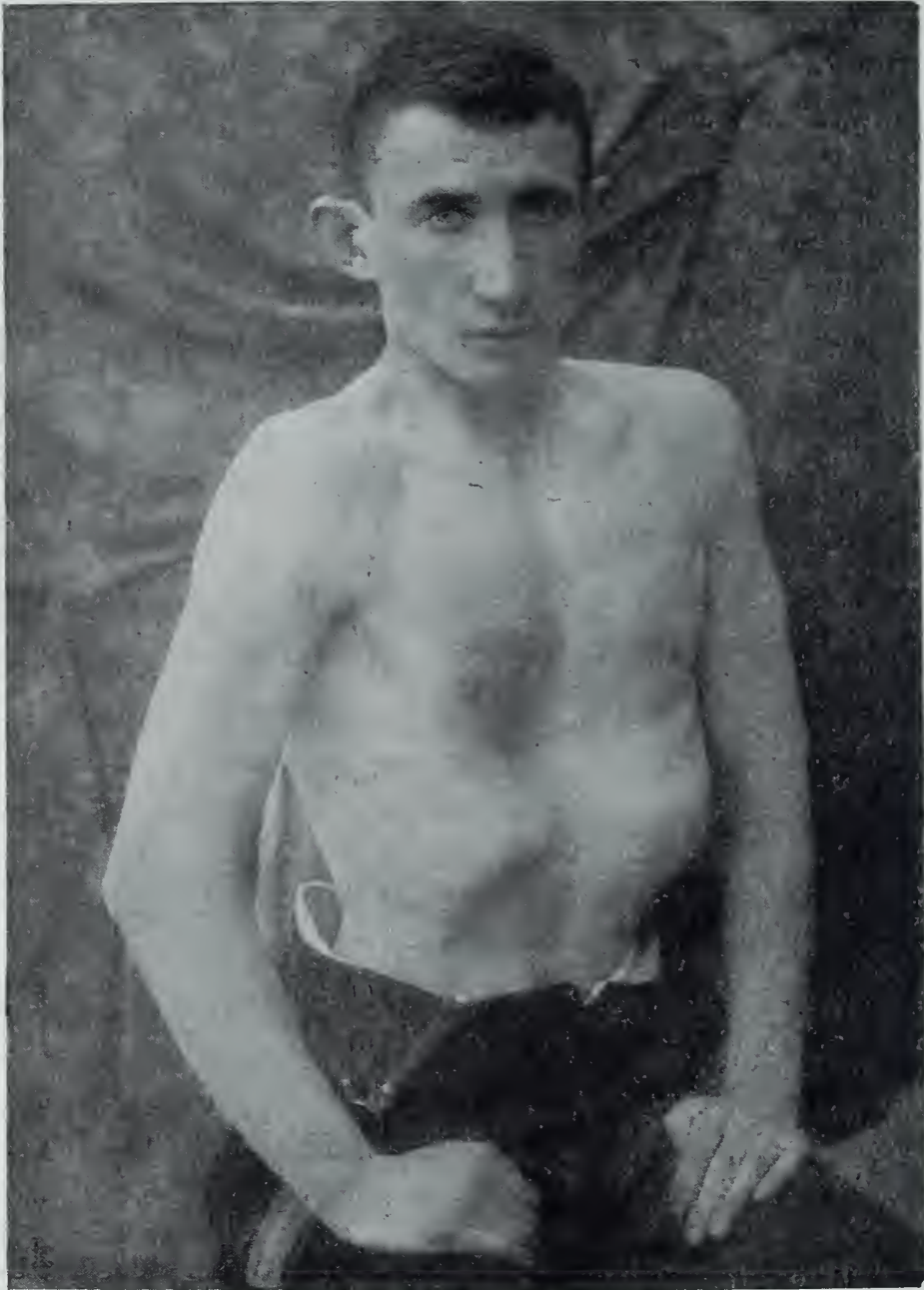
The three cases referred to are, as far as I know, all that are on record. In one, the patient was an elderly man, and the other two had both attained adult age. In all the growth appeared to have stopped. This patient will probably afford us other opportunities for observing his condition. A photograph has been kept for the Museum.

X.—*Tubercular Ulcer on Tongue.*

We have had before us some most instructive examples of different diseases of the tongue. In one case I ventured to diagnose a tubercular ulcer. The patient was a delicate man of middle age with suspicious symptoms of chest disease. The ulcer was near the tip of his tongue and had raised and rather ragged edges, with a slightly undermined border and a grey base. The absence of all tendency to papillary growth and of any material induration about the base seemed to justify the diagnosis. I advised its excision.

XI.—*On a Case of Funnel Chest, or “Trichter-brust.”*

The portrait given below represents the condition of a young man who attended one of my demonstrations at Park Crescent in September of 1886. He has, I believe, been made the subject of lecture at several of our metropolitan hospitals. He attended my demonstration at the



Polyclinic in July last. The peculiarities of his chest are not very successfully represented in the woodcut. In the living subject the depression at the lower part of the sternum is most striking. The following remarks on the deformity have been written for me by my nephew, Dr. Woods Hutchinson :—

This singular malformation of the chest was shown at the Surgical Clinic on July 6th, by the kindness of Dr. Sequeira. There was a deep depression of the lower end of the sternum, a little to the right of the median line and 2 inches below the nipple. The ribs and cartilages swelled out above and upon both sides of this crater-like pit, giving almost the impression that the chest had been crushed in by some tremendous blow or spear thrust.

The patient was a young man of 23, slight, and rather anæmic, but otherwise apparently healthy. He says that the deformity began when he was about three or four years old and is still increasing, notably, he thinks, within the past two or three years: which, however, being interpreted, probably means that the condition is congenital, and has existed since his earliest recollection, and that the increase of the deformity has been purely relative, on account of this portion of the chest-wall being immovably fixed and unable to develop *pari passu* with the rest of its expanse. Thus the lateral aspects of the front of the thorax, in their growth, have "ballooned" out above and upon both sides of it. As to its rapid increase in the past few years, so as to incapacitate him for any active work, as he declared, it was found that he had taken to exhibiting himself as a curiosity, and the distaste for hard labour thereby engendered might colour his statements somewhat. There was nothing in his occupation to produce pressure in this region, or in any way tend to increase the deformity. The tremendous bulging forward of the cartilages of the lower ribs caused the upper portion of the abdomen to appear as if collapsed, but this region and its viscera were normal, and their positively deformed appearance was only by contrast with the projecting chest-wall. Indeed, the part played by contrast in the production of the entire deformity was very great, as is shown by the fact that measurement with the calipers gave the distance between the dorsal spines and the deepest portion of the depression as 15 centimetres, or only a little more than 4 centimetres below the normal average diameter at this level. At first glance the funnel appeared more than as many inches in depth, and probably would reach almost this depression, reckoning from the most prominent swell of the cartilages. The transverse diameter of his chest, at the level of the depression, was 28 centimetres, thus giving him a chest-index of 54. This is one of the lowest yet recorded, the normal being 71.

Nothing certain is known as to the causation of this curious condition. The chief factor is evidently some influence which binds down the lower end of the sternum and prevents it from yielding and moving forward as the chest grows and increases in size, but whether this be a thickened and shortened band in the central tendon of the diaphragm, or an error of growth, causing the tip of the sternum to curve backward as it elongates, or some obscure arrest of development, we have no data sufficient to decide. The first suggestion would appear the most probable.

COLLEGE NOTES.

CLINICAL lectures will be delivered during this month—on the 11th by Dr. W. Miller Ord, on “The Clinical Relations of Arthritis,” and on the 25th by Professor Dreschfeld, of Manchester. The Council have agreed that in future, subject to the acquiescence of the lecturer, a short discussion will be invited after each lecture. The utilisation of the large room upstairs has proved a step in the right direction. The accommodation is better, the room more comfortable, and the lecturer much more easily heard.

* * *

THE first annual report is a fairly satisfactory *résumé* of the progress of the College from the date of its opening in May, 1899, till the end of the year. It records a creditable amount of work accomplished and indicates that the various departments are now completely organised, or in process of speedily becoming so. The working arrangements of a new institution cannot be expected to be faultlessly perfect from the commencement; time is required to discover the weak points, and in the light of experience to remedy them. Among the notable features of the report, attention is first attracted by the list of members and subscribers, which reaches a total of 606. This is a remarkable achievement in such a short space of time and points conclusively to the need experienced in the profession for such post-graduate opportunities as we offer. With such a response to the initial invitation of the Council, it will be strange if early and complete success is not secured. What is required is that each individual member of that sum total of 606

should lay the interests of the College to heart and make an effort to help its advancement, as every one may do in the following ways:— By taking a personal part in its work; by bringing forward cases of unusual interest for demonstration and discussion; by attending as regularly as possible the clinics and lectures; and by proclaiming its merits to his neighbours and professional friends with a view to increasing the size of the membership-roll. The larger the membership becomes, the wider will the influence of the Polyclinic extend, and if it is to achieve the success which those most concerned in its management desire, that influence will eventually be world-wide, and the opportunities in London for post-graduation instruction and study will be second to none in any similar College either in Europe or America. Difficulties have to be contended with and overcome, but any that so far have declared themselves may be speedily overcome if two conditions are fulfilled:—1st. If the management is efficient and enterprising; and 2nd. If the members and subscribers as a body unite to promote the interests of the College. If we may judge from the attendances, which form another satisfactory feature of the report, the latter condition would seem to be fully appreciated, as every week shows a steady increase over its predecessor in the numbers present at the lectures and consultations. The fulfilment of the former condition can only be decided by the test of time; early faults and failures in organisation must be condoned if they are remedied when discovered, but the electorate of the College have it in their power to control the management by annually filling up vacancies on the Council with men whose professional status and business capacity ensure efficiency of administration and direction. The list of life governors is another pleasant surprise, it already comprises 39 names, and of these nearly one half are laymen. This points to a non-professional interest in the Polyclinic which it is desirable to cultivate. The professional advantages of our work are by no means our only recommendation, there is a charitable side to our existence, equally important, offering opportunities to the benevolence of the public, which this list tempts us to hope will be abundantly responded to when our claims are known and understood. The financial side of most “first reports” is disappointing, but a total subscription to Capital of close upon £3,600, and a commencing Income of £700 is not a bad basis upon which to found hopes of early relief in the matter of “ways and means.” On

the whole, the progress so far attained is distinctly encouraging, and the report sets forth concisely our position as at December 31st last.

* * *

THE Schedule of Consultations and Lectures for the April-July term is now in the hands of members. It presents a comprehensive programme for the ensuing four months, and to those who attend regularly it may safely be affirmed that there is a prospect held out of a fairly extensive survey of the greater part of the field both of medicine and surgery. It is gratifying to note so many well-known and distinguished names on this announcement list. The practical sympathy with our scheme thus afforded by these gentlemen is deeply appreciated by the Council, and will be no less gratefully accepted by every member of the College.

* * *

THE total attendance of members at the College during the month of February amounted to 959, being an increase of 190 over the attendance of January. One result of this increase has been larger clinics all round, in some cases so large that whispers have been heard of uncomfortable crowding round the patient, and of occasional difficulty in hearing what the consultant has to say of the case. The gentlemen in charge of the consultations are begged to make a note of this. Both faults, if they really exist, are easily remedied.

* * *

THE two lectures delivered by Dr. Patrick Manson during February, on "The Malaria Parasites and Malarial Disease," were masterpieces on a subject of which he is *facile princeps*. He delighted a large and attentive audience with a veritable fairy tale of science, and the way in which he showed how, beginning with Laveran's original discovery of the plasmodium, one set of incidents logically guided his own and other investigations in the direction of further discovery, made his audience appreciate how true, or nearly true, it is that "genius consists in the capacity for taking pains." During the long period of 30 years Dr. Manson has been directing his attention to this great question of malaria, and no patient investigation has ever been rewarded with more signal success. The last link in the chain of plasmodium evolution is now furnished by the stages of its life history, which can be demonstrated in the tissues of the *Anopheles* variety of mosquito. All that

is required to make these discoveries invaluable is to hit upon a plan whereby this mosquito can be effectively dealt with, and if possible annihilated. Malaria is the most formidable of all tropical diseases, and is responsible for an annual mortality of some millions, and the disablement of many millions more. Not the least charm of Dr. Manson's lectures was their extemporaneous delivery. They were illustrated by many diagrams, and by a beautiful collection of microscopic specimens, showing every stage in the life history of the parasite, as it occurs both in man and the mosquito. Since the opening of the Polyclinic no lectures have excited more general interest, and it is the universal hope of the members that it may not be long before Dr. Manson tells us another tropical story.

* * *

THE Laboratory has been open since the beginning of March, and may now be inspected by members at any time during the afternoon. The class on Clinical Microscopy has proved attractive, and Captain Pinch has been compelled to organise a second course, which it is proposed to hold once a week, on Thursday at 5.30 p.m. The analysis of morbid specimens apparently supplies a want among members, as considerable advantage has already been taken of the facilities offered. On payment of a small fee members can be supplied at the Laboratory with suitable bottles and cases for the transmission of specimens. A printed tariff of fees is in course of preparation, and will shortly be procurable on application.

* * *

DURING February 715 members attended the 17 consultations which were held. Many interesting types of disease were demonstrated and discussed, and no fewer than 76 cases were sent up, being the largest number of patients which the Polyclinic has received in any one month since its opening. This is, so far as it goes, an indication of progress, but members are again reminded that it is to them the Executive look for widening the scope of our usefulness in this direction.

* * *

IN accordance with the Articles of Association the whole Council retired at the Annual Meeting on the 28th ult., but, being eligible, offered themselves, with the exception of Mr. Herbert W. Page, for

re-election. They were duly appointed for another year, and Dr. Patrick Manson was elected to fill the vacancy caused by Mr. Page's retirement. The Council is to be congratulated upon the accession of Dr. Manson; their choice could not have fallen upon a more suitable man, nor upon one more acceptable to the general body of members and subscribers.

* * *

THERE has been considerable diversity of opinion expressed recently on the wisdom, or otherwise, of having increased the annual subscription to two guineas. The step was decided upon by the Council after very careful consideration. The annual subscription, it ought to be remembered, carries with it substantial privileges. It entitles the subscriber—

- (1) To the free use of the Library, Reading Room, and Museum.
 - (2) To attend as often as he pleases the cliniques in the various Consultation Rooms, the Wednesday afternoon Clinical Lectures, and the meetings of the Investigation Sub-Committees.
 - (3) To receive every month, post free, a copy of the College Journal—THE POLYCLINIC.
 - (4) To have access, for purposes of original research, to the Laboratory, and also to have pathological specimens examined and reported upon at a nominal fee.
 - (5) To the use, under certain conditions, of one of the Consultation Rooms for the demonstration to members of the College of private cases.
 - (6) To become a member of the College on application after approval by the Council.
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NOTES ON THE MEDICAL AND SURGICAL ASPECTS OF THE WAR.

AMONGST what may be regarded as the minor items on the credit side of the balance-sheet of a war, we have certain increments of knowledge which almost invariably result. Napoleon took with him into Egypt a little corps of savants, and Alexander the Great in Persia took pleasure in collecting natural history specimens for Aristotle's use. Excepting in a military or Bullerian sense, it is true that not much of the area likely to be visited by our troops in South Africa can be described as "unknown country." Still, however, there is much work to be done in many departments of observation, and it is certain that our knowledge of ethnology, climatology, zoology, and local prevalence of disease is likely to receive important additions from the observations of the highly trained men who are at present accompanying our armies. Their chief duty of attention to the wounded will not probably absorb all their time, and we may confidently hope that, whilst the war will most certainly serve as a very valuable means of education to the Boers, it will not be wholly without its harvest for ourselves.

In all that relates to battle-wounds and their treatment, we shall, no doubt, have abundance of well-observed and well-digested facts. Those on the spot will know better what to observe than those at a distance, and it would be almost an impertinence to attempt suggestions.

Apart from matters of direct practical interest, we may fully trust such men as Sir W. McCormac, Mr. Treves, Mr. Watson Cheyne, Mr. Makins, and their colleagues not to neglect the opportunities for physiological observations which the rough experiments of the battle-field so often afford.

We have already ventured to suggest (*THE POLYCLINIC*, p. 65) that, when circumstances permit, some attempt should be made to examine the dead as well as the wounded to ascertain what are the kind of injuries which are the more common causes of death. Such observations might be made of definite use in future wars.

The nature of "heat exhaustion" and of "sunstroke," the cause or causes of dysentery and enteric fever in connection with camp life, are also topics which need the multiplied and exact observation which they will doubtless receive.

In reference to various articles of food and their relative value in the maintenance of health, we also hope for gain in our knowledge, not only from the experience of soldiers on march, but from those who have had to endure the privations of a siege. It was one of Sir John Cormack's observations during the siege of Paris that the men maintained their strength well on claret and a little bread alone. It will be of much interest to know what estimate has been formed in the present war as to the value or otherwise of alcoholics, and as to the relative usefulness of the direct nerve-nutrients, tea, coffee, and cocoa. Have the smokers borne privation and fatigue better or worse than those who, if there were any, did not smoke?

In reference to zoological observations, the war has inflicted a distinct loss in the tragic death of Dr. Stark in Ladysmith. This distinguished naturalist was, as many will remember, killed by a shell at the door of his hotel, exclaiming with his last breath, "Take care of my cat——" meaning, it is believed, had he been able to finish the word, a catalogue of Natal insects upon which he had been engaged. It is certain, however, that in the ranks of our army—which comprise now many highly-educated men—there will be some well competent to observe and record in all the departments of zoology, botany, and meteorology. Insect life abounds in South Africa, and presents many curious features which need elucidation.

It is to be hoped, also, that there will be found some who will not think it an unworthy task to gather up such scraps as they can obtain as to the habits, food, mode of life, diseases, &c., of native and bastard races of the regions through which our armies pass. Above all, we want trustworthy information as to the use of salted fish, and as to the local prevalence of leprosy. As a last suggestion may be added an earnest hope that no English surgeon who may have on his hands an idle day in Cape Town will neglect the opportunity of a visit to Robben Island. He may there see with his own eyes the various phases which leprosy assumes, and may also realise the social attractions of a Segregation Hospital. Wednesdays and Fridays are the packet days, but a boat may be hired at any time.

At the meeting of the Committee now engaged in South African investigation, on the 21st ult., Dr. Alfred Hillier produced some chest shields for bullets. The one previously shown by Mr. Hutchinson

was of aluminium, and had not succeeded in turning the bullet. Dr. Hillier's shields are of prepared steel, and one of them has proved quite impervious to bullets fired at a distance of 100 yards. They are moulded to fit the cardiac region, but are large enough to diffuse the impact, and also to protect almost half the thorax. They may be seen at the Polyclinic on application to Captain Pinch.

CORRESPONDENCE AND ANSWERS.

DR. H.—You will find at p. 49 of *Hirsch's Handbook*, vol. ii, the following :—
 “There has never been a case known in which the physicians or nurses of a leper home have caught the disease, although they mix with the patients without restraint, dress their sores, and sometimes even wound themselves in so doing.”

* * *

SYPHILIS.—If anyone is unconvinced as to the fact that syphilis was unknown in England before the end of the fifteenth century, let him read two papers by Mr. William Becket, Surgeon and F.R.S., in the *Philosophical Transactions* for 1720. They are entitled “On the Antiquity of the Venereal Disease,” and the author assumes that he has proved that syphilis “was known among us some centuries before the siege of Naples.” After a laborious citation of evidence, however, all that he has proved is that a contagious “burning” was known to be the result of impure sexual intercourse. He believes this to be “the same as common clap,” and to be the first stage of syphilis. He adduces no proof whatever that any of the ordinary, secondary, or tertiary phenomena of syphilis had been recognised as the consequences of these attacks of “burning,” and is driven to the supposition that what authors described under the name of leprosy was really constitutional syphilis. The entire failure of a strong partisan familiar with the literature of the subject, and nearly two centuries nearer to the times under investigation than we are, is a very strong argument as to the non-existence of any evidence.

* * *

A CASE FOR OPINION.—The following statement is submitted to us :—A woman was delivered, after a tedious labour, of a very fine but dead infant. It was her first, and she was in excellent health. She had felt the movements of the child strongly 48 hours before its delivery. In the placenta were found two or three indurations, “almost calcareous,” and the husband, on being questioned, admitted having had syphilis 13 years before. He had, however, for many years been entirely free from symptoms. We are asked whether the indurations of the placenta could be regarded as a trustworthy indication of taint? The answer must be that the healthy development of the foetus up to the end of term proves that the placenta was not seriously diseased, and makes it necessary to seek for some other explanation of the death. It is scarcely conceivable that a placenta which had sufficed for the vigorous nutrition of its dependent foetus for nine months, could then

cause its sudden death. The sudden death in utero of a well-grown and very healthy-looking foetus must be attributed to some accident, or at any rate left unexplained, for nothing that we know of such a disease as syphilis, whether as affecting the placenta or the foetus itself, would account for it. In deaths from syphilis, cachexia must precede termination of life. We are thrown, then, on the conditions discovered in the placenta, for the death of the child is valueless as evidence. As 13 years had elapsed since the paternal syphilis, it is improbable in the highest degree that any transmission of taint could occur, and it may be doubted whether the conditions described in the placenta ought to be allowed much weight against it.

* * *

ENQUIRER is, of course, quite right in his supposition that Sir John Cormack was no relation to the present distinguished president of the College of Surgeons. Their names are spelt quite differently. Both, however, had experience of warfare, for Sir John was in Paris during the famous siege, and accompanied the French forces in more than one attempt to break through the ranks of their besiegers. He was the trusted adviser of Sir Richard Wallace, and physician to the Hertford British Hospital in Paris. He was a most conscientious and diligent observer of disease, and only just missed becoming a very distinguished physician. His two volumes of *Clinical Studies* are well worth reading.

* * *

A CORRESPONDENT writes:—"I was called to see a married woman at the full term on January 23rd, and was told that just a month before she had had connection with her husband, and had afterwards discovered that he was under treatment for disease. She left him, and subsequently found a sore on one labium. I feel sure that it is an indurated chancre. She was delivered of a healthy child on the 30th. I am giving her mercury, but ought the child also to be treated?"—*Ans.*: Better wait events. The exposure to risk was only a little more than a month before delivery, and the child may not improbably have escaped. You have done right to forbid the mother to nurse her child, and in warning her as to the danger of infecting it.

* * *

TWINS AND INHERITED SYPHILIS.—Dr. William Campbell, in his *Illustrations of Congenital Syphilis* (1874), has recorded the following fact:—"In the summer of 1823 a pupil of my class delivered a woman in Rose Street of twin males, at full time. The first was dead and much decomposed, while the second was living, plump, and apparently healthy. We were unable to account for this remarkable difference for some weeks, when the secret was revealed by the living infant exhibiting unequivocal evidences of syphilis; and shortly thereafter the female parent also became affected with tertiary symptoms."

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. II., No. 5.—MAY, 1900.

TUBERCULOSIS AND LEPROSY—A PARALLEL.

IN many features the problems presented in the study of tuberculosis are similar to those of leprosy. In each instance we have a malady of almost world-wide prevalence attended in all the more typical and well-pronounced stages by a specific bacillus. In each the presence of this parasite might suggest that it was the one sole cause of the malady, and that the latter could spread only by its communications from one person to another. In both cases, however, the evidence in support of this *a priori* creed is somewhat weak, and the negative facts abundant. No one doubts, however, that the bacillus of tubercle is inoculable, and that therefore the disease may under favouring circumstances be contagious, whilst similar statements as regards that of leprosy are as yet mere probabilities, and rest only on assumption. That in both what may be called contributory or predisposing causes are of immense importance is universally admitted, and it may be suggested that the questions which press for investigation concern chiefly the nature of those contributory causes and the precise share which they take in the development of the disease.

We may note at once that leprosy is a somewhat less protean disease than tuberculosis, that it keeps more closely to its type, and is not credited with the parentage of such a variety of phenomena, that also it is more restricted in its prevalence, and manifests a more definite

tendency alike to local increase and to local decadence. Although tubercular maladies prevail much more largely in some districts than in others, they can scarcely be said to be endemic anywhere, nor perhaps is there any country from which they are wholly absent. These facts are otherwise in the case of leprosy, for there are large districts where it was formerly prevalent from which it has wholly died out, and others in which it has steadily or even rapidly increased. The inference seems legitimate that the influences which favour the activity of the leprosy bacillus are of a more definite and specialised character than those which befriend that of tuberculosis.

The question as regards the possible latency of the bacillus—by which is meant its presence in the tissues without any revealing phenomena—is much the same for the two maladies. In both it is quite impossible to assign any limitation to the duration of the so-called stage of incubation. It has been proved that a victim may show the first obvious signs of leprosy 20 years after having left the place where he contracted it. Respecting tuberculosis it is rarely possible to assign any date for its commencement, but general experience will probably justify the assertion that there are plenty of cases in which the evidence suggests the belief that the bacillus has remained in a state of quietude for very long periods. In certain cases of lupus relapses have been observed 30 years after a cure, and in such we can only believe that the bacillus has remained in symbiotic union with the tissues during the whole interval. That in cases of inoculation the incubation period may be short has been proved in the case of tuberculosis, at any rate so far as experiments in animals can go; but respecting leprosy we have no facts. As regards heredity the nature of the evidence is in the two diseases much the same. Both were in former days presumed to be very commonly inherited, and in both scepticism has originated in connection with recent and more exact observations. Since, however, the presence of the tubercle-bacillus has been repeatedly demonstrated in the newly born, both of animals and mankind, we cannot doubt that tuberculosis may be inherited. No similar evidence exists in the case of leprosy, but the very early age at which it has been observed makes it not improbable that in exceptional cases the bacillus may pass from parent to child. That inheritance in this definite form is rare, both in tuberculosis and leprosy, and especially so in the latter, is very probable. As to the inheritance of tissues weak in vital endowment, and therefore

easy of attack by the bacillus, there is good reason for believing that it is powerful in tuberculosis and of little or no importance in leprosy.

The food question has a twofold aspect as regards both the maladies. It is possible that the bacillus itself may be conveyed in some article of diet—and in reference to tuberculosis both raw milk and meat are held to be dangerous—and it is further possible that without being a direct vehicle of contagion the diet may, either by deficiency or excess, or by the presence of some stimulating ingredient, become the means of favouring the activity of the parasite. In the case of leprosy there is great reason to suspect that uncooked fish does tend in some way to develop the disease, whether by introducing the bacillus or merely by exciting its vitality is as yet an open question. That a liberal regimen—plenty of fresh meat, fatty foods, and a moderate allowance of alcohol—tends in both instances to favour recovery is unquestionable, whilst it is equally certain that no amount of the most judicious liberality will serve in all cases as a prophylactic. Both leprosy and tuberculosis, but especially the former, may originate in those who have enjoyed every advantage as regards food, clothing, and fresh air. We may take it, then, as proved that in each instance, in certain cases, the specific cause may be powerful enough to overbear all antagonistic conditions. It follows that in each there is a specific something which serves as the means of systemic infection and produces the ostensible phenomena which we name as the disease. That specific something is in all probability the bacillus, or some representative form of it, in symbiotic union with the tissues.

Leprosy and tuberculosis appear to have in common a tendency to run their course. Both may, of course, cause death, but in both if, under favourable circumstances, the patient lives on, his malady comes to a standstill. In leprosy the patient may be left blind and crippled; and in tuberculosis we may have large portions of lung destroyed, or a joint may be ankylosed, so that in neither can the term “cure” be applied if by it is to be meant restoration to a state of health. In both, however, recovery is attained, so far as cessation of all active processes of disease is concerned. In the case of leprosy this appears to be the usual result if the patient is removed to a country where the disease is unknown, and it is probably not infrequent even in those who remain at home or become the inmates of a leper-house. The duration of the period of activity is in both diseases to be measured by

years, but in both it appears to be terminable ; and from this we may perhaps infer that there is something in the life history of the contagion which is adverse to its indefinite prolongation of life.

The facts, which are exceptional to the suggestion that in either disease the ordinary mode of spreading is by personal contagion, are much alike in the two. We are assured that the nurses in hospitals for consumption do not become consumptive, and the same is asserted as regards the attendants in leper-homes. Husband and wife may live together for years, the one consumptive the other never becoming so ; and it is just the same in leprosy. In both it is exceedingly common for the disease to originate in those who are quite unaware that they have ever been exposed to any risk of contagion.

It would be of great interest if we could ascertain whether leprosy and tuberculosis under any conditions display a tendency to substitute each other. In other words, is it ever observed that where leprosy is common tuberculosis is rare or *vice versâ* ? Iceland is, perhaps, the only place where anything of this kind has been suggested, but enquiry might, perhaps, bring other instances to light. In the case of yaws and syphilis, in which this law of substitution is said to hold, the fact has been used as an argument for the identity of the two diseases. There is no question that a great many leprosy patients die of tuberculosis of the lungs, and, having regard to the close similarity of the bacillus in the two cases, the suggestion is not an altogether random one, that after all the one disease is only the other modified by peculiarities in diet.

A very interesting fact remains for mention, and with it we must conclude our parallel. In one form of leprosy—the macular erythematous or anæsthetic—the bacillus is never found in the tissues of the skin. That it is there we may be sure, and that this form of leprosy is identical with the others there can be no doubt. Now there is a form of tubercular disease of the skin—lupus erythematosus—in which, although its alliance with the others and with tuberculosis in general cannot be doubted, yet the tubercle bacillus cannot be discovered. Lupus erythematosus presents indeed some features of very curious similarity and contrast with erythematous leprosy.

J. H.

LEPROSY IN MADAGASCAR.

DR. ANDREW DAVIDSON, a medical missionary, communicated to the Medico-Chirurgical Society of Edinburgh, in 1864, a very able article on Leprosy in Madagascar. He discussed the various aspects of the question with great intelligence and fairness. His opinions in the main were adverse to the belief in contagion, but he was quite unable to find any other explanation. He wrote:—"It is highly probable that the same originating causes, which at first gave rise to leprosy, are still in existence, and endemic in certain localities. *It may spring up now and then under certain circumstances, de novo, without contagion or hereditary taint. What the originating causes are is a profound mystery.*" "In the island of Madagascar there are a number of different races. They occupy widely varying climates. The circumstances and modes of life of these races are as varied as are their origins and the nature of the localities in which they reside. Yet leprosy affects all alike. The Hoval who lives in European fashion, and in a temperate climate, is no more exempt from this scourge than the African slave." "It occurs where fish is an article of food, and also where no fish is to be had, and where rice and vegetables satisfy the simple wants of the population." "Race, geographical position, and diet all seem absolutely unimportant elements in relation to its presence or its spread." (*Edinburgh Medical Journal*, July, 1864.)

Now it may be remarked respecting these statements that the fish-hypothesis would meet all Dr. Davidson's difficulties, were it not for his supposed fact that some lepers have never eaten fish. This statement is, we venture to believe, made on insufficient information, and in forgetfulness of the fact that salt-fish may go where no fresh fish is obtainable. There is nothing in Dr. Davidson's language to suggest that he had ever enquired as to salt-fish, and he was probably thinking solely of districts where living fish are taken. We have been assured by missionaries who have laboured in Madagascar since Davidson's time, that there are no districts where dried fish is not obtainable, and that everywhere it is a most acceptable condiment for the tasteless rice which is the staple food.

J. H.

FIGHTING A CHIMERA.

A STRANGE rumour reaches us from New York. It is estimated that there may be as many as a hundred lepers now residing in that city. All of them are, of course, imported cases. It is proposed, in face of this terrible risk, to at once found a large leper-establishment for their segregation, and Yellowstone Park is mentioned as a suitable place. It is supposed that there may be found a position sufficiently isolated to make the rest of the Union safe. Now this measure is to be taken—or is at least suggested, which is, it is to be hoped, a very different matter—in spite of the fact that no single instance of contagion has occurred. Never, perhaps, was there a more egregious example of blind trust in hypothesis. Leprosy has a bacillus, therefore leprosy is spread by contagion; therefore let us isolate all lepers. All the evidence goes to show that leprosy can no more thrive in the United States than monkeys could flourish in English woods. A leper deported into the States either dies or gets well, probably the latter; but he gives his disease neither to his neighbours nor his children. Surely until these assertions can be invalidated, it would be well to pause, and not rashly to adopt measures which may be the cause of heavy expense to the State, and of untold misery to those immediately concerned.

J. H.

DEVICES FOR THE EXAMINATION AND TREATMENT OF THE STOMACH.

IN few departments of medicine have greater inventiveness and mechanical ingenuity been displayed during the past few years than in the study of gastric disturbances. Since the introduction of systematic lavage and the test-meal, gastrologists have vied with each other in the devising of new instruments and methods the more interesting of which are described by Lincoln in *The Medical News* (N.Y.), January, 1900. Some of these have proved most valuable additions to the gastric armamentarium, while others have been little better than ingenious fads. Among the latter must as yet be classed the gastroscope, with its combination of mirrors, for bringing into the field of vision the various portions of the gastric mucosa. The

difficulties of its use, and its discomfort to the patient are great, and the size of the patch of surface which can be seen in one image so small, that the process of exploring any region of the viscus in its entirety is a slow and tedious one.

The same objections apply to the "camera" for intragastric photography. It is so skilfully designed that it is perfectly workable, but the minute size of the plates which it is possible to take detracts greatly from their value.

The gastro-diaphane, however, is a much more practical instrument, and has been in almost daily use in several consultation rooms. It consists of a small incandescent lamp attached to the tip of an ordinary soft stomach tube, with its connecting wires running up through the tube to a battery. The patient is placed in a dark room with the abdomen uncovered, and the tube is then passed into the stomach in the ordinary way with the lamp at its tip. When properly in position the current is turned on and the position and size of the stomach brought into view by illumination from within, though the effect is a most uncanny one. Any tumours in the anterior wall can also be brought into relief as dark shadows. It is advisable to wash out the stomach and then partially fill with water before using the instrument, so as to avoid any possible irritation of the mucous membrane from the heating of the lamp globe. The process is no more disagreeable to the patient than the use of an ordinary stomach tube or bougie.

The most successful form of the instrument is that devised by Einhorn of New York.

Of course the X rays are pressed into the service of gastric diagnosis by the clever device of coating the interior of the stomach by means of a gastric insufflator with bismuth, which is impermeable to the rays, and enables a radiograph showing the size and much of the outline of the viscus to be taken. A metallic capsule swallowed by the patient may also be followed on its course and the position of the intestinal tract mapped out by a series of X ray photographs.

A grateful substitute for the disagreeable tube in many cases is the gastric bucket. This is an olive-shaped silver cup, an inch deep by half an inch wide, with a strong silk thread attached to it. It is passed well behind the epiglottis with the tip of the finger, and then simply swallowed by the patient, thus avoiding the distressing constant choking pressure of the tube at the level of the larynx. After

remaining in the stomach for four or five minutes it is drawn up again by the thread, filled with the contents of the viscus for analysis.

The instrument is said to be much easier and pleasanter to use than the tube, the only points of difficulty or resistance being the cardiac orifice and the level of the larynx when drawing the bucket up again, but of course it is of no value for lavage purposes, and the amount of stomach contents which can be brought up in it is very small, for purposes of examination.

Powder-blowers, sprays, and electrodes for the direct treatment and stimulation of the gastric mucosa are simple achievements, but the climax of mechanical treatment and purely local view of gastric disturbances is the gyromele of Turck. This is a tube containing a flexible cable with a sponge attached to its tip which can be thrust out into the stomach after the tube has been introduced. To the upper end of the cable-rod is attached a hand-piece, by turning which the extended sponge can be rapidly rotated in the stomach, thus literally scrubbing out its interior. Thus the bacteria which, according to the view of its inventor, are the real cause of dyspepsia and gastritis can be removed bodily, and the disease cured at once. Oliver Wendell Holmes once suggested that a scraper should be devised for cleaning coated tongues, but this "laundry" view of gastric therapeutics, as it has been scoffingly termed, is certainly beyond even his quaint conceit.

W. H.

HEAT IN THE KARROO DISTRICT.—"During the heat of the day the wagon was untenable ; it was a privilege to recline on a karross spread on the short grass, under a thick Doornboom, in the bed of the river, which was quite dry, except at the spring."—(*Backhouse.*)

"March 7th.—The difficulty in writing was great ; if the pen was taken off the paper for a moment the ink at its point was dry. Flies were extremely numerous ; they settled often on the pen and tried to drink the ink from it ; and unless the inkstand was kept closed, they continually got into the ink. The paper became so brittle that care was required not to break it in folding it ; and the nails of the thumbs especially had a tendency to reverse their convexity, and to become detached at the tips."

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON A CASE OF EXOPHTHALMOS AND OTHERS.

BY W. M. ORD, M.D., F.R.C.P.

Tuesday, March 13th, 1900.

GENTLEMEN,—This is a case of very great importance and difficulty. You will observe that the patient has marked exophthalmos in the right eye, and, if anything, a little drooping in the left upper eyelid. With this exophthalmos, she has a very distinct enlargement of the thyroid. The beginning of this she cannot quite trace. She thinks that it did not commence till after she was married. Of course, one must accept that statement, although I think with some qualification. It will be obvious to all of you that she has a distinct projection in the position of the thyroid body, and I think you will all see that the projection is a little larger on the right side than on the left. The tumour moves with the act of swallowing. She has with this several of the conditions that ordinarily accompany this kind of swelling, namely, tremors, palpitations, and a very quick pulse. To-day it is between 120 and 130. Dr. Roe, who brings her here, tells me that the pulse has once or twice gone up to 164. The tumour itself is rather a firm one, and over it I can hear no murmurs. It is not at all tender, and the redness that is to be seen over it is due to the application of iodine. She tells me, however, that she experiences distress in swallowing. I do not think that this can be in any way due to mechanical pressure, because the tumour is well clear of the upper part of the sternum, and moves freely away from it. There can be, I think, no pressure behind the sternum that could cause it, and I do not think there is likely to be any pressure on the trachea itself. She says she is subject to attacks of violent palpitation, and I suppose that it is in some of those that the pulse has been found so quick, but she does not appear to have any regurgitation, indicating that there might be an obstruction in the

oesophagus, nor is there any history of actual vomiting—all things that one would look for in connection with exophthalmic goitre. There is a great deal of weakness, and there has been a considerable falling off of the hair. She does not appear to have had hæmorrhages. People suffering with this trouble are very apt to have hæmorrhages, epistaxis in particular, sometimes hæmorrhages from the bowels, sometimes excessive uterine hæmorrhage, but Dr. Roe tells me there was no excessive loss in her parturition. Again, she has no signs of affection of the hands, such as would go with imperfect circulation, and as far as I can make out she has no changes in her joints. In one way this would seem to be a very average case of mild and not very thoroughly developed Graves's disease. The uncommon point about it is that the exophthalmos is limited to one eye. Of course, I have seen a great deal of exophthalmos, having paid a good deal of attention to the disease, but I never remember to have seen one eye only affected. This being so, and considering that there is a little more fulness on the right side than on the left, I have been trying to find whether there may be any difference in the size of the arteries on the two sides of the neck. I have, however, not been able to satisfy myself about that, and will ask some of you to give me your opinion about it presently. She is easily excited, always at work on something, whether tired or not. Incessant stimulation to activity of some kind or another is very characteristic of the disease. She seems rather silent to-day, but she is not generally so.

Of course, this is obviously a case of Graves's disease which I do not think would have engaged our attention very long but for the inequality in the eyes. She has most of the ordinary symptoms, and perhaps one of the most important among them is the preternatural activity of the subjects. They are the most restless people almost that one meets with; they are incessantly wanting to do fresh things, and always inclined to complain of great fatigue. One feels quite sure that after the prolonged examination she will be very much excited. Another thing that goes with the great activity is a tendency to garrulity. Such patients generally talk all the time, but she does not manifest that symptom to-day. She has the falling out of the hair, the tremors and the great weakness, and it is of interest to find that this seems to have commenced since her marriage, and that she has born two children within two years from the time of her marriage. I have no doubt the

disease has to do in the majority of cases with the changes of menstruation. That is my experience over a large period, and this is precisely one of the cases of firm thyroid enlargement which I should expect to go on to a diminution of the thyroid and ultimately myxœdema. This is an extremely frequent occurrence. With regard to the treatment of such cases, we know that belladonna is a very valuable drug, particularly where the pulse is so quick. To be of use it must be given in fairly full doses, and I should be inclined to give her, in addition to the belladonna, iodide of potassium and hypophosphite of soda. Arsenic is a good tonic, and as she is obviously very weak, both this and iron are, I think, indicated.

CASE II.—We turn our attention now to another case. This patient has, as you will observe, a number of irregular movements of the head and neck with contraction of the muscles, sometimes on one side, sometimes on the other. She has twitchings of the face from time to time so that the muscles stand out. She seems to have no twitchings in the arms and hands, but there is a history of her legs giving way occasionally. She seems, as far as I can make out in the short time I have seen her, not to have lost muscular power in any way. She has no difficulty in speaking or swallowing.

The condition here appears to be more or less choreic, and one knows that chorea certainly in many cases has its origin in nervous shock. I suppose that in the cases I have seen, something like 30 per cent. appear to have had an antecedent history of some kind of mental shock or possibly a blow with or without insensibility. Of course, that is independent of those which are associated with acute rheumatism. I can find in her no sign of affection of the heart. There appears to have been no affection of the joints, but if the case is choreic the duration is very unusual, and, of course, the age that she gives, 25 years, is one which is also contrary to ordinary observation. The movements stop completely during sleep. I think this is the purely neurotic form of chorea.

I have made many experiments with regard to the production of chorea through nerve shock in animals, and I have also examined many spinal cords of animals after various kinds of shocks, and I am inclined to think that in animals, at all events, very violent shocks applied to the spinal region result in rupture of the fibrils communicating between

the cells of the anterior horns of the cord. It is a very difficult thing to prove. Of course, those examinations are extremely refined, but in the *Proceedings of the Royal Society* is contained a paper in which I have detailed in full the changes following the administration of very strong electrical shocks to the spinal cord, and it has seemed to me that it is just possible—I do not put it forward as a real argument, only to be thought about—in cases of mental shock, as in cases of electrical shock, the communications between the cells and the cord may be impaired and disordered with the result of excitement being set up and inco-ordinated movement following.

With regard to treatment, arsenic might be useful but I really do not know how to treat a case of this kind. I think if one had her under observation for some time one would try various things, such as Indian hemp, belladonna, and bromide in large doses. Sometimes when these cases are very bad, and the irregular spasm is so troublesome as to interfere with eating, speech, and deglutition, one may give chloroform for a time to enable feeding to go on. In place of that I am very much in the habit, in severe cases, of using an ether spray down the nape of the neck for a time, and this, without affecting the patient's consciousness, stops the spasm so completely as to allow of feeding.

CASE III.—Our third case is that of a patient who is 83 years of age. He is, as you see, a man who is more or less emaciated. I should like you to notice the position of the xiphoid cartilage. It curves upwards in contrast with the retraction of the abdomen, and there is also a projection of the ribs. It seems to me that this is always very helpful in estimating what a man's proper abdominal curve should have been. A man, as he gets older, of course has the xiphoid more and more firmly fixed to the rest of the sternum, and so, after 60, it retains the line that in the man's active life has been the curvature of his abdomen. I always call it the high-water mark of the man's abdomen. This patient's is a little flexible even at his advanced age. It is quite clear that he has been much fatter. The diaphragm is acting well, and his abdomen is symmetrical above, but below it is obvious that there is a considerable projection, which would correspond very much to the cæcum. When he first came into the room there was another projection, namely, a rupture, which has now disappeared under the fingers.

The tumour is a firm one, and does not move at all with the diaphragm. On manipulation one finds it nodulated and tender. He appears to have no weakness or pain in the right leg, and it seems to me that the tumour, whatever it is, is not attached to the back of the abdomen with any firmness. It is not likely, therefore, *primâ facie*, to be producing pressure upon nerves, or to be connected with the bone. It has more the appearance in every way of a malignant growth, probably connected with the intestine, but one has to think of other things which it might be. It certainly seems to be permanent. I do not think it can be any accumulation in the bowel that might give rise to the idea of tumour. We must remember that it is stated that his motions are black. It certainly is not bony. It is far too large to be due to calculi, and the kidney region is quite free from any sign of swelling. I am afraid we can only regard it as a malignant growth.

CASE IV.—Our next patient is thin, slightly anæmic, breathes rather quickly, complains of pains in her limbs, and has a history of rheumatic fever on several occasions. She has a double aortic murmur, distinct regurgitation, has an entire absence of the closure sound of the valve, which is replaced by a murmur. At the same time, I could hardly call the pulse regurgitant. She has a loud double murmur at the impulse, which I should call systolic and diastolic, which is also audible at the back. Over the pulmonary area there is some accentuation of the second sound, but not as much as I should have expected, and this I think is partly related with a want of increase in the impulse. I think the heart is an exceedingly feeble one and not producing the effects of the pulse or impulse that one would expect. There is very little hypertrophy or dilatation of the heart. She complains of a good deal of pain in her limbs, and the finger joints are very considerably enlarged. The latter may be a part of acute rheumatism going on into a chronic form in some of the joints, but I think this enlargement is more due to her occupation. The case is a very typical one of rather extensive valvular disease of the heart.

CASE V.—After a brief examination I think this patient presents the conditions of tabes dorsalis. The history is rather curious. In the first place there is no story of syphilis, which is supposed generally to be the main cause, but he had, as is described, a feeling of walking on soft

things ; very often one of the earliest disorders of innervation. I have looked at his feet to see whether there was any sign of ulceration. One occasionally finds in relation with that particular sensation an ulcer in the sole of the foot, but in this case there is no sign of that, and there seems to be no evidence of affection of joints other than one of the left knee-joint, which is the result of an injury. He has small pupils which do not react to light but do to accommodation. He appears to have occasional lightning pains and something like gastric crises. He has no trouble with the bowels and can usually pass water freely. There is no doubt he has a good many signs of ataxy. His walk is ataxic and he says he cannot stand with his eyes shut, but he has a splint on one leg which no doubt causes him some little difficulty in this regard. He has certainly not lost power in his legs. The case has many of the characters of ataxia, but not all, and I am not satisfied about his being able to keep his leg flexed against my pressure, although he kept it straight against my pressure. Of course, after all, the conditions here are in a fairly early stage of development, because as the disease advances we get affections of the eyes going on to colour blindness, affections of the bladder going on to paralysis and requiring relief by catheter, more pronounced gastric crises, and another very important crisis, the laryngeal crisis, which is due to a sudden failure in the abductors. Where you hear that a man has had crises consisting in sudden attacks of choking, you very often find that the abductors of the vocal cords are not acting as well as they ought, so that there is some tendency for the cords to drop in a little curve. In many cases I have seen that condition excited before the man had the laryngeal crisis. When it gets worse, the laryngeal crisis develops and unless you perform tracheotomy the patient is lost.

THE SEASONS IN NATAL.—Summer, hot and rainy ; winter, cold and dry. Durban and Maritzburg—December, January, and February : mean temperature, 71·2 ; June, July, and August, 56·7. From July to December (end of winter and beginning of spring) the upper districts are subject to hot winds, which make vegetables droop, and induce languor and depression in all animal life. These do not come nearer the coast than 20 miles.

ON CASES OF INHERITED SYPHILIS IN ADULTS WITH EXCEPTIONAL FEATURES.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

(*Concluded from p. 240.*)

WE have been for six months past observing with great interest a case which Mr. Johnson Smith, of the Dreadnought Hospital, has been good enough to send us. The patient, a man of about 30, has a fusiform enlargement of the middle of his left femur, and the question has been syphilitic periostitis or sarcoma. There is no history of acquired syphilis, and nothing to suggest inherited taint. As time has gone on, and the swelling has not increased, the suggestion of sarcoma, which at the first visit seemed the most probable diagnosis, has faded from our minds. On the other hand, syphilitic remedies, which have (although the history is absent) been fairly tried, have not removed the swelling. Mr. Johnson Smith has recently explored the swelling by a free incision over the middle of the bone and taken away a disc by the trephine, and he informs me that he found only ossifying periostitis. Now, bearing in mind that it is possible for an adult to be the subject of inherited taint whilst yet showing no revealing symptoms, I cannot avoid a suspicion that this man may possibly be a case in point. I have ventured, at any rate, to suggest to my friend that both mercury and iodide should be given together, and that the latter should be pushed. The thickening, which is very considerable, must, I think, be syphilitic, and the negative evidence as regard acquired disease is strong.

Large Gummata in the Liver.

The next case which I will mention is the one which we have most recently seen. It is only a month since I brought before you a young man who had been sent to me by Dr. Sharman, of Dulwich, and who had two large tumours in his liver. He attended again two weeks later, and the unanimous opinion was that the tumours were both smaller and softer. He had during the fortnight been taking iodide of potassium. Now what were the items of evidence upon which we had on the first occasion based a diagnosis of gummata in connection with inherited

taint? You will remember that the tumours projected so as to be easily visible, and felt much like two small oranges placed side by side, one in the left lobe of the liver, and the other adjoining it to the right of the epigastrium. No one doubted that the tumours were in the liver, for its contour could be felt, and the only question was as to their nature. They were quite painless, and you were all in succession allowed to examine them freely. They were tense and smoothly rounded, with the exception that a smaller knot, about the size of a marble, could be made out on the surface of one of them. I had examined the patient at my own house before I produced him to you, but I did not announce my diagnosis, preferring to allow all to form their own impressions. I believe that the general opinion was that they were hydatids, and this, I may confess, was my own opinion in the first instance. It is true that they did not definitely fluctuate, but then hydatid tumours are often so tense that it is difficult to feel certain upon this point, and it was impossible to be sure in this instance that fluctuation was absent. Our patient was a young man of 22, in good health, who had not complained of any special symptoms. He had discovered the lumps himself about three months ago, and had consulted Dr. Sharman about them a week or two before he was sent to me.

I have told you that my first diagnosis was hydatid cysts, and this opinion I entertained without reservation until, having noticed that the man spoke as if he had a cleft palate, I asked him to let me look into his throat. This at once disclosed the fact that his uvula and soft palate had been destroyed by ulceration, and that the latter was represented by a tight scar, which crossed about half an inch behind the margin of the hard palate. Further examination showed that there was a large perforation of the nasal septum, and that in both eyes the corneæ were slightly hazy, and the irides defective in lustre and with adhesions at their margins. Here, then, we had a group of symptoms in themselves almost conclusive, and they were clinched by finding an osseous node on one tibia, which had a scar on its surface, and from which I was told fragments of bone had been exfoliated some years ago. The young man, who was inclined to make light of his ailments, and would scarcely admit that he had ever had either inflamed eyes or sore throat, attributed this node to a kick at football, but it is not usual for such results to follow such an injury. When pressed he did admit having been under treatment both for his eyes and his throat some years ago, but

we may take note, as an instance of the difficulty which sometimes attends the extraction of evidence, he would very willingly have denied both. Some patients have, as we all know, a sort of pride in ignoring and denying all past illnesses, and he appeared to be one of this class. It is needless to say that there was nothing in his physiognomy which had attracted my attention, and it may now be added that on looking at his teeth they gave us no help. The diagnosis, however—with a node on one tibia, iritic adhesions, corneal haze, a large scar in the soft palate, and a perforation of the septum—was clear, and at once helped us to the opinion that the lumps in the liver were really gummata in connection with inherited taint.

On the second occasion Dr. Sharman was kind enough, at my request, to send with the patient his elder sister. She was two years older than her brother, and was the eldest living in the family. As you saw, she was a tall, well-grown woman, who showed not the slightest peculiarity of physiognomy. Her face, which is very unusual with heredito-syphilitics, was very florid, and covered with acne spots. Her upper incisor teeth were broken by caries, so that they showed nothing definite, and the rest were not peculiar. The revelation of her taint was, however, in her eyes. Her sight was very defective, especially so in the left, and in both there were iritic adhesions and clouds of haze in the corneæ. She gave the history of a severe attack of keratitis at the age of 12. There were reported to be in the family four other children, all, of course, younger than the two with whom we are concerned, and none of whom have suffered anything.*

Now, Gentlemen, as I think you will all admit that I have established my diagnosis of inherited syphilis in these two patients, many and very interesting questions suggest themselves for our consideration. In the first place, let me say that it is very probable that neither of them presented any symptoms in infancy which were suspected—very likely none at all. Neither of them show in their teeth any proof of having

* The following details as to the family have been supplied to me by Dr. Sharman :—

Father, not seen, reported healthy. Mother, in good health. First child (boy, seven months'), dead at birth. Second (girl), died 3 months old, bronchitis. Third, Ada, 27 years ; H.S. Fourth, our patient (male), 25 years ; H.S. Fifth (male), 24 years ; no trace of H.S. Sixth (girl), 21 years ; no trace of H.S. Seventh (boy), 19 years ; no trace of H.S. Eighth (boy), 16 years ; no trace of H.S.

taken mercury, neither of them show the physiognomy or the damaged skin which so frequently reveal the taint. In both the bridge of the nose is good. It is, perhaps, not very uncommon for syphilitic infants to show no proof of taint, just as many of those who have had true chancres never show any eruption or sore throat. It is a mistake to suppose that in syphilis the full *rôle* of phenomena is always completed. Very often it is not so. Let us bear in mind how very easily in such cases as these the diagnosis might be wholly missed. It is under such circumstances often cruelly inconsiderate to ask direct questions of parents, and even if it were not so the result would seldom help us much. In the present case we carefully avoided it, but I have Dr. Sharman's assurance that neither of the parents has, so far as they have been under his observation, shown any evidence of taint. We have been informed also that four other brothers and sisters are all free from suspicion. If it be suggested that some of them may yet show symptoms, I will say in reply that I do not think it likely. It is the ordinary history for the eldest child, or perhaps the first and second, to suffer and for the rest to escape. The taint unquestionably dies out, and not only do the parents retain good health, but their younger children are often free from symptoms and enjoy excellent health. You will find some important statistical evidence on this point in my work on *Syphilitic Affections of the Eye*, by which it is shown that in a very large proportion of cases those who suffer from interstitial keratitis are the eldest-born of their parents.

It may be worth our while to note that if after the birth of these patients the taint had been recognised and their parents, one or both, had been put through a course of mercury, the escape of the younger children would have been triumphantly claimed as having resulted from it. Let us remember that time as well as mercury cures syphilis.

As regards the special feature of our present case, the formation of large visceral gummata, it may be admitted at once that it is an example of what is very rare. Neither in acquired nor in inherited syphilis are gummata of a size sufficient to be mistaken for tumours of other kinds at all common. Curiously enough when they do occur they often happen to patients otherwise in good health, who show no cachexia and no other signs of their taint. They disappear with almost marvellous rapidity under treatment by iodide of potassium, and, what is perhaps yet more wonderful, they seldom recur. Nor do those who

suffer from them subsequently experience, as a rule, any other specific trouble. Thus they appear to be, if we may so speak, a sort of local accidents. They grow quickly like malignant tumours, but vanish as if at Prospero's wand, when the iodide touches them. Some of those now present will, I am sure, remember well a case which illustrated these remarks, the subject of which came under our observation repeatedly some years ago when our clinical demonstrations were at Park Crescent. Two sisters, women of about 30 years of age, were both of them the subjects of inherited taint, and one of them had a tumour-gumma in her tongue. The lump was as big as a marble, and almost as hard. It projected visibly both on the upper and under surfaces of the tongue, occupying its whole substance. This patient attended once a week in order that we might note the rate at which the lump was absorbed. In less than a month, I think, it was quite gone. Now the history of these two women was known to me from their infancy. I had attended their father and themselves, and had seen them both through severe attacks of interstitial keratitis at about the age of 10. They were within a year or two of the same age, and none others had been born in their family. After recovery from their attacks of keratitis both of them had enjoyed good health, and with the exception of this gumma in the tongue, both of them continued to do so. It is now three years since we cured the gumma, and I believe that nothing else has happened to either of them.

Epiphysitis in an Infant.

Last January an infant, two months old, was brought to us by Mr. Sequeira, in whom simulated paralysis of the upper extremities, with evidence of pain when they were lifted, had suggested the diagnosis of inflammation about the epiphyses at the elbow. This diagnosis of Mr. Sequeira's was confirmed on examination. There could be no doubt that, in both limbs, there was swelling of the ends of the bones both above and below the joints, more especially of the lower end of the humerus. The elbow joints were free, and could be moved if it were done gently; any pressure on the bones, however, made the child cry. The child was well grown and looked fairly well, there being no other symptom of syphilis excepting snuffles. Both father and mother attended with it, and both appeared to be in good health. The father

had denied to Dr. Sequeira that he had suffered from syphilis. One other infant had been born dead, and this was the only one they had living.

I remarked that there could be not the slightest hesitation as to the diagnosis, and that it was of interest to observe how almost entirely the usual symptoms of inherited taint might be absent. The mother was nursing the child, and I advised that she should continue to do so, and that one-grain doses of iodide of potassium should, in the first instance, be given to the infant. The child has since, I am informed, been taken home to Italy, so that we shall not know the sequel.

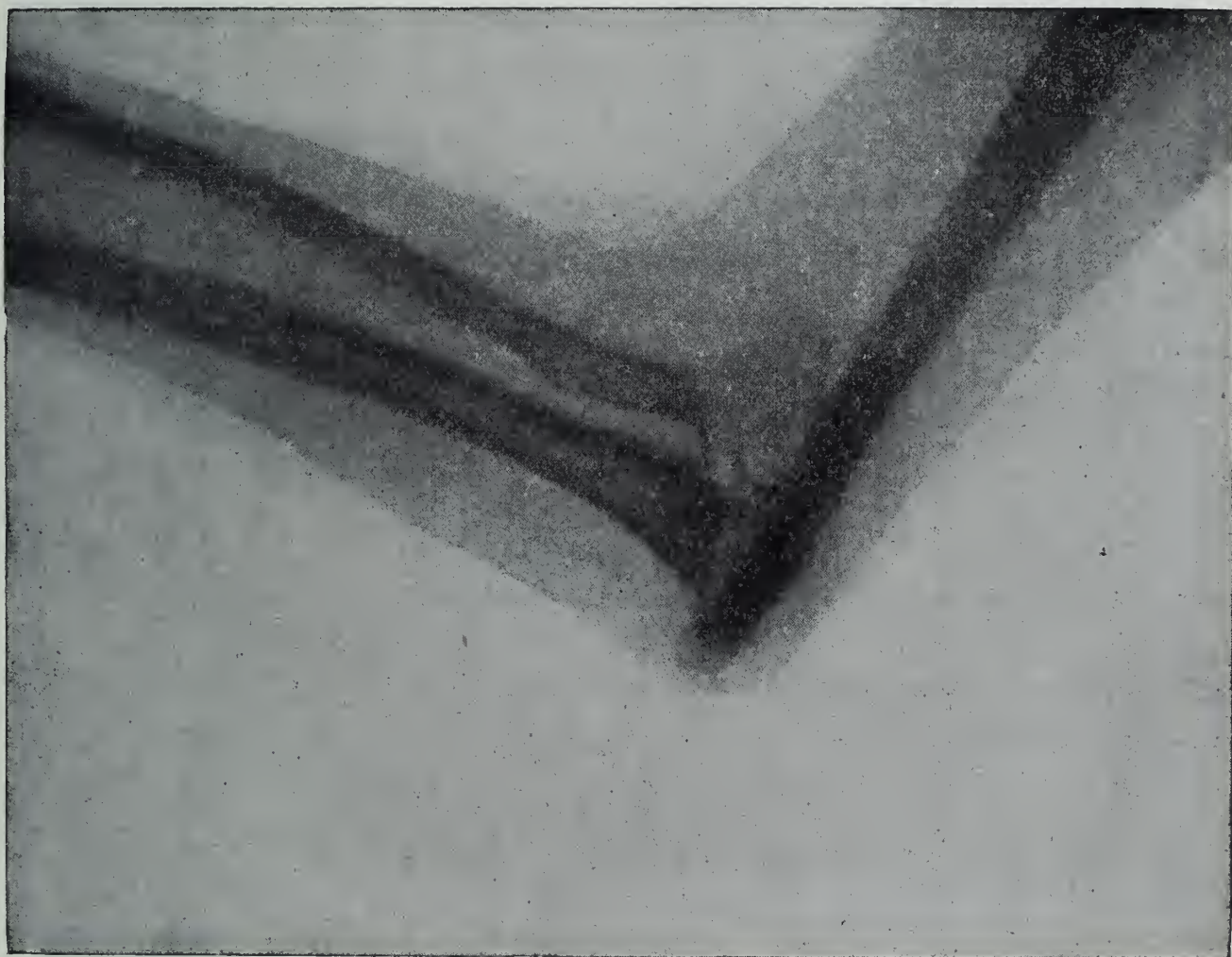
Remarkable Deformity at the Elbow-Joint.

I have mentioned Dr. Sequeira's case because I wished to introduce the topic of the very remarkable deformities of the elbow-joint which sometimes occur in inherited syphilis. I have seen several of these and have recorded them, and although I cannot say that I have ever been able to prove their connection with epiphysitis, yet the suggestion that they are so is very probable. An inflammation of the lower part of the shaft of a long bone, involving its epiphysis, and occurring at an early period of life, may be supposed very likely to result in arrest of growth and great modifications of form. Whether this suggestion is adequate in the instance of the patient of whose elbow I now show you a skiagraph, it is difficult to say. The diagnosis as regards the patient's inheritance is not free from uncertainty. The condition of the elbow is one of the most extraordinary that I have ever seen.

It is the right elbow which presents the conditions which I have to describe. A blunt end of bone projects below, and is at first mistaken for the olecranon, but on examination the latter is found to be two inches above it, resting against the outer side of the humerus, the end of which (the projection mentioned) is all that remains. The end of the radius, in apposition with the ulna, and of course yet more superficial, is easily visible in almost its whole extent. It still rotates freely, and with its companion bone moves within certain limits of flexion and extension. It is not in apposition with any part of the humerus. Thus we have a dislocation of both bones upwards on the side of the shaft of the humerus, the latter having undergone extraordinary modifications in form. The elbow is very thin, and the bones are covered

only by a thin white scar, which extends for a considerable distance above and below what remains of the joint.

There is no history of any injury. The statement is that disease occurred in the joint at the age of 10 or 11; that portions of bone came away; that the limb was in splints for a year; that amputation was proposed, and was only averted by a consultation with Sir James Paget. The ulceration of the skin must have been of a lupoid character and very extensive to have left so large and such an abruptly margined



Skiagraph showing the deformed and pointed end of the humerus projecting below the level of the bones of the forearm. The latter rest against the side of the shaft of the humerus.

scar. The question is, Was the disease struma or congenital syphilis? and it is one not easy to answer. Miss W. is now 40 years of age, and she comes attended by a sister two years older than herself.

Both sisters bear traces of having suffered severely from symmetrical inflammation of their corneæ. The conditions, although suspicious, are, however, not quite characteristic, and are such as might possibly have

been caused by ulceration. The central opacities have not wholly cleared, and very marked arcus senilis (an unusual condition in middle-aged women) prevents any critical examination of the margin. Neither of the sisters has a characteristic physiognomy, and both have lost their upper front teeth, and are wearing artificial ones. Both of them are deaf, the younger one very much so, but then there is the history of otorrhœa after scarlet fever. They have lost their parents, and no history of infancy is obtainable. Their two younger sisters both died of pulmonary phthisis. The younger of these two suffers from ozœna, and her soft palate on the right side is adherent to the posterior pharynx, evidently as the result of ulceration. Thus there are a number of items of evidence which, taken together, make it very probable that the disease of the elbow was really due to inherited taint.

In connection with the absence of ankylosis in this case, we must remember that it is a peculiarity of syphilitic epiphyseal disease that the bones may suffer very severely whilst the joint itself remains intact. Thus, with very extensive destruction of bone, there may be no ankylosis. This escape can scarcely take place in strumous disease, in which almost invariably the cartilages suffer.

Absence of Most of the Usual Signs of Inherited Syphilis.

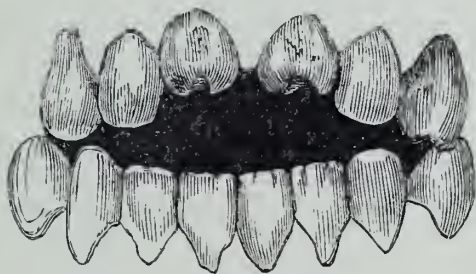
A young woman, aged 22, who was brought by Dr. Isaacs, showed in her physiognomy not the slightest evidence of inherited taint. She had white teeth with good enamel, and all of perfect form, excepting the two upper central incisors. These latter were short, defective at their edges, and showed broad notches. She was a well-grown woman of rather handsome features, although very pale. Dr. Isaacs gave the history that he had treated her for a severe attack of interstitial keratitis about four years ago, and although it had passed off very satisfactorily, her pupils were motionless. The right was somewhat irregular at its margin, and much larger than the other. Nothing was known as to family history beyond the fact that she was an only child, and that her father had led "a fast life."

I asked attention, when this patient was before us, to her good teeth, and to the absence of any peculiarities in physiognomy, and said that, in all probability, there had been no infantile symptoms, and that no mercury had been given. Yet the attack of keratitis, and the mal-

formation of the upper central incisors, made it certain that she was the subject of inherited taint. I also drew attention to the fact that the diagnosis might easily have been missed. The teeth and the keratitis supported each other, but in the absence of either the case might have been deemed to prove that the one which was alone present was independent of taint.

The patient had been brought for consultation, on account of attacks of pain to which she was liable in her face and other parts. There was a history of inflamed knees at the date of her keratitis, and she still had pains in her legs. There was no proof of periostitis in any bones, and the character of the pains, taken with the motionless pupils, suggested suspicion as to tabes. Her patellar reflexes were, however, quite good. I mentioned that the pupils were often left very sluggish after severe attacks of keratitis, and advised the employment of atropine to ascertain whether, in the present instance, there were adhesions sufficient to explain the immobility.

The sketch which I show may serve to remind you of this patient's dentition, showing the deformity of the upper central incisors and the



Dwarfing and Notching of the Upper Central Incisors, with Escape of the Rest.
A Typical Condition.

escape of all the others. It was, however, taken from another patient, and the dwarfing and notching of the two incisors is much more marked than it was in Dr. Isaacs' patient.

SOUR MILK.—Galton, writing about the Damara tribe of South Africa, says that "like all other milk-drinking nations they use it only when sour and the cow is milked into the tainted vessels. They firmly believe that a cow's milk will fail her if they milk her into anything freshly washed and clean."

* * *

HORSE SICKNESS IN SOUTH AFRICA.—Galton, describing horse sickness in South Africa, speaks of "that fatal scourge, the distemper. First one fine mule was found to be ill and to stand with difficulty; a little froth gathered about his nose and mouth; in an hour he was lying on the ground, and in another hour dead.' It may be noted that the Damara natives eat the dead mules.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

SURGICAL CASES.

BY JAMES BERRY, F.R.C.S.

December 6th and 20th, 1899, and January 3rd, 1900.

AMONG the cases shown on these occasions were the following:—

CASE I.—*Calculous Pyonephrosis.*

A woman, aged 33, with a swelling in the left loin. She had had pain in this region for some four years, and had been aware of the presence of a lump for about the same time. At the beginning of the illness she had been under treatment in another hospital, where the diagnosis of tuberculous kidney had been made, and removal had been advised. The pain was of a dull aching character, with occasional sharper attacks shooting down into the left groin. The urine contained much pus, but no blood. There had never been any hæmaturia. No tubercle bacilli could be detected. There was no undue frequency of micturition, or any other signs pointing to affection of the bladder.

The diagnosis of the case was discussed. The shape and situation of the swelling, and its relation to the colon, pointed clearly to its renal nature, while the pyuria and the tenderness indicated suppuration. The diagnosis lay between tuberculous and calculous pyonephrosis. The absence of tubercle bacilli in the urine, and the absence of any other tuberculous lesion in the body, together with the long duration of the symptoms, were against the former. Stress was laid on the fact that the absence of hæmaturia did not by any means negative the diagnosis of calculus. Similar cases of renal calculus without hæmaturia were quoted. Other means of diagnosis, such as the use of Röntgen rays and the injection of some of the pus into a guinea-pig, were mentioned. As regards treatment, it was concluded that the best treatment would be a lumbar incision to let out the pus, and to remove

the calculus, if one were found. The subsequent treatment of the kidney, whether by nephrectomy or not, would depend largely upon the extent to which the kidney had been disorganised.

[At a subsequent demonstration a large branched calculus was shown that had been removed, together with a large quantity of pus from this kidney.]

CASE II.—*Cirroid Aneurism of the Forehead.*

A man, aged 19, from whom a large cirroid aneurism had been removed. The aneurism (of which a photograph was shown) occupied



most of the left side of the forehead, and encroached upon the hairy portion of the scalp. The vessels of the left and anterior quarter of the scalp were also greatly dilated. The tumour had been treated by free excision. The hæmorrhage, although abundant for a minute or two had been easily controlled. The large open wound was immediately covered with Thiersch's skin grafts, and the unsightliness of the scar thereby greatly diminished.

CASE III.—An elderly man, with a large rodent ulcer of the forehead.

CASE IV.—A girl with an old and very badly united fracture of the upper third of the femur. There were several inches of shortening and the patient was very lame. The best means of treating this case were discussed, and it was concluded that an osteotomy (necessarily an open one) would improve the patient's condition. [This operation was subsequently performed with great advantage to the patient.]

CASE V.—A woman with a swelling on the inner side of the head of the tibia, the exact nature of which was uncertain. As it had apparently existed for a long time, and caused no trouble, and as the woman's general condition was not good, no operation was advised.

CASE VI.—A young woman whose nose had been, in infancy, completely eaten away by a ferret, and upon whom numerous plastic operations had been performed at various times in her life for the alleviation of the deformity.

One demonstration was devoted to affections of the hip. On this occasion two cases of congenital dislocation of the hip were shown as well as a series of cases of tuberculous disease of the hip from the Alexandra Hospital for Hip Disease. The diagnosis of these affections was discussed.

OPHTHALMOLOGICAL CASES.

BY HOLMES SPICER, F.R.C.S.

March 2nd, 1900.

CASE I.—*Relapsing Bullous Keratitis or "Relapsing Abrasion" of the Cornea.*

THE patient, a man of 25, sustained a slight scratch abrasion of the cornea a few months ago, which healed fairly promptly, as such injuries usually do, but was followed a few weeks later by the spontaneous appearance of an apparently similar lesion upon the precise site of the original scratch-mark. This is characteristic of this curious form of disease, an injury occurs, and then at intervals tends to "repeat

itself," so to speak, especially in the cold or changeable weather of the spring or autumn. Upon careful observation it will be found that a tiny bulla or vesicle forms over the site of the original injury, but this rapidly ruptures, and its delicate wall is rubbed away, leaving beneath it a shallow simple abrasion of the corneal surface, which sometimes develops into an ulcer. This heals in the course of a week or two, only to repeat the process in the course of a few months. Women are more subject to the disease than men, and its attacks may coincide in them with the menstrual periods, especially if the latter are attended with much difficulty or pain. It may also occur in connection with successive attacks of malaria, and is then said to be relieved by the administration of quinine.

Fortunately, the ulcer seldom attacks the true substance of the cornea, being usually confined to the epithelial layer, so that opacities or permanent scars are never produced, but the disease is extremely painful and most annoying on account of its obstinate recurrences. The present case is rapidly recovering from his last attack, so that the disease has passed its most characteristic stage, but a linear vertical streak of greyish opacity can be seen at the lower border of the cornea almost in the median line. There is marked circumcorneal congestion, evidently lying below the conjunctiva, and a good deal of photophobia and lachrymation.

CASE II.—*Keratitis Profunda.*

The patient, a poorly-nourished, broken-down man of 43, states that his right eye began to smart and water and his sight to fail, without any apparent cause, some six weeks ago. He now shows a large, roughened-looking, greyish patch of opacity in the central region of the cornea, completely covering the pupil, and upon closer scrutiny a deep, whitish infiltration of the middle layers of the cornea can be seen. There is a good deal of deep-seated rather venous-looking congestion around the cornea, but surprisingly little pain or photophobia, the patient complaining chiefly of the dimness of vision and permanently "watery" condition of the eye.

The case is a typical one of keratitis profunda, a slow degenerative form of interstitial keratitis, which, though it resembles certain stages of the well-known specific disturbance of that name, is not in any way connected with or dependent upon syphilis. It is usually associated

with a lowered condition of the general nutrition, as is the case in the present patient, and the cornea seems to suffer from failure of the peripheral circulation. On account of its lack of direct blood supply, the substance of the cornea is one of the most remote "extremities" of the body, and degenerative changes readily occur in it as a result of either wasting disease or any prolonged failure of the general nutrition.

CASE III.—*Severe Form of Tobacco Amblyopia.*

This case is at first sight a puzzling one. A man of 56, whose vision is so seriously reduced that he can scarcely count fingers at six feet, and is unable to walk about by himself, and yet whose media, fundi, and discs are perfectly normal in appearance. Upon testing with the perimeter his fields of vision are normal in extent and shape, and it is only when the central vision is tested that any impairment is found.

There is a central scotoma which is practically absolute, not only for colours but for form.

He has no cerebral or other nervous symptoms, and the only condition which corresponds accurately to this symptom-group is tobacco amblyopia.

This affection is due to an inflammation of the axial fibres of the optic nerve, and usually clears up completely within a short time of the complete stoppage of the use of tobacco, but in cases where the failure has lasted as long and become as complete as in this patient, the condition may become permanent, so that a guarded prognosis must be given here. The greatest difficulty in the treatment of these cases lies in inducing the patients to give up tobacco completely. They will haunt the hospital for months complaining bitterly of the persistence of the blindness, and vowing that they have completely stopped their tobacco in every form, until one day they are accidentally caught smoking, or perhaps chewing if smoking especially has been forbidden.

The other cases presented were:—

CASE IV.—Calcareous degeneration of the lens, with anterior and posterior synechiae following perforating ulcer of the cornea.

CASE V.—Result of tattooing a large central lensoma in a boy of 14, presented at a previous consultation.

CASE VI.—Double iritis with adhesions of gonorrhoeal rheumatic origin, in a man of 29.

CASE VII.—Double lamellar cataract for which iridectomy had been done without adequate relief and a complete removal of lens now proposed by needling and free breaking up of lens substance.

DERMATOLOGICAL CASES.

BY T. COLCOTT FOX, M.B.

March 12th.

Cases of Infantile Prurigo.

DR. COLCOTT FOX first exhibited three infants suffering from the very common affection variously described as *Strophulus intertinctus seu pruriginosus*, *Lichen urticatus seu pruriginosus seu strophulosus*, *Urticaria papulosa*, *Prurigo infantilis seu simplex seu temporanea autotoxica*—an affection most inadequately described in the textbooks. He further illustrated the subject by a series of portraits which set forth on the one hand the extraordinary multiformity of aspect encountered, and, on the other hand, served to give a coherent conception of the affection as a whole.

CASE I showed the typical papular phase widely disseminated without a trace of any erythematous element or urticarial wheal, yet the mother stated that the child was “smothered in blisters,” *i.e.*, red or white blotches, at night, and two days previously many red, erythematous macules, the size of the finger nail, centred by papules were observed.

CASE II showed, mixed with the papules, a number of varicelliform vesicles, some of each being set in an erythematous macule.

CASE III was also a vesicular case, and displayed, on the sole of one foot, a perfect clear bulla the size of a pea.

Dr. Fox said there was a great diversity of opinion as to the sequence of the elements of the eruption found present. Some observers

thought a state of itching the essential feature, and the eruptive symptoms secondary to rubbing and scratching; others thought any erythematous blotches and wheals present were secondary to the papules, and so on. The exhibitor had convinced himself that the essential eruptive element was an evanescent erythematous macule, the size of a split pea or the finger nail, centred by a more persistent papule, or sometimes a vesicle, or more rarely a pustule. The blotch and the papule might be quite urticarial and white. The vesicle might have dry cornified walls as in varioloid, or be almost indistinguishable from varicella, or occur about the hands and feet as pemphigoid bullæ. All degrees of secondary pus inoculation might complicate the picture, but never any of the peculiar thickening or inflammation of the skin known as lichenification or eczematisation.

The *etiology and pathology* were also obscure. Assuming that the reflex functions were very active and the higher restraining centres in the infant weak, it is possible that many excitants might be in action, such as turgescence of the skin in hot weather, from excessive clothing, overheated rooms, &c., the irritation of clothing and insects, reflex influences from a disordered gastro-intestinal tract, or auto-intoxication. Some of these influences were often present, and the children might be ricketty or syphilitic. The lines of *treatment* therefore appeared to be in the counteraction of any such influences. The list of special internal remedies recommended was very large, but he had not been very successful with them, *e.g.*, ichthyol, antipyrin, belladonna, bichloride of mercury, &c. It was most important to prevent scratching, and to administer some sedative at night, such as chloral, or trional, or perhaps opium. Locally many applications, such as ichthyol, liquor carbonis detergens, liq. plumbi diacetatis, carbolic acid, &c., were useful palliatives. As for *diagnosis*, the most expert were for a time at fault in some cases. Varicella might be closely simulated in some vesicular outbursts, and the flattened involuting papules might closely resemble lichen planus papules. Scabies, however, was the common stumbling block. The resemblance was often close, especially as the hands and feet were affected, but the absence of cuniculi, the freedom of other members of the family, the presence of characteristic macules, &c., were to be observed.

Cases of Lupus Vulgaris.

Dr. Fox then demonstrated and contrasted two very dissimilar cases of *lupus vulgaris*.

CASE IV was that of a girl, aged $4\frac{1}{2}$ years, with thick, raised, infiltrated, scaly patches of considerable size over the knees, the left elbow, around the wrists, and on the buttocks. One small spot had disappeared from one heel. The eruption evolved at about six months of age as little pimples, but the mother was rather vague as to whether the pimples appeared simultaneously or at intervals. The baby was very delicate at the time. Maternal grandfather died of phthisis, otherwise no clue to family tuberculosis. There were no satellite apple-jelly nodules, but the diagnosis was founded on the thick infiltrated character of the lesions, the date of origin, the slow extension, and the scarring left by the patch on the elbow. Probably the lesions were of internal origin, the infective agent being disseminated from some tuberculous centre. The whole was now practically quiescent.

CASE V was that of a girl, aged 14 years, with ulcerated areas of lupus vulgaris across the nose, cheeks, and ears, in the distribution-areas of lupus erythematosus. Here also there were no satellite apple-jelly nodules, and the patches were vegetative or thickly encrusted. The lesions originated in infancy, and followed the suppuration of glands above one elbow, in the groins, &c. There was disease of one os calcis with sinuses, presumably tuberculous. This case was active, and had repeatedly relapsed after thorough scraping and cauterisation with chloride of zinc paste. Dr. Fox said that he proposed to have complete excision and grafting carried out, but the cure of the extensive implication of the palpebral conjunctiva of the right eye presented difficulties. The diagnosis depended on the presence of persistent patches of dense cellular infiltration arranged across the face, leaving scars, and spreading slowly over the conjunctiva and skin, and the glandular and bone lesions were corroborative. Syphilis would not persist for years in this way. Still, the positive proof of its nature must depend on the histology and inoculation experiments, for it might possibly be blastomycetic dermatitis. The ulceration and sprouting of unhealthy granulations were not peculiar to lupus.

A Case of Xanthoma with Jaundice.

The last case was that of a woman, Rebecca H., aged 53, suffering for six years from jaundice. An enlarged liver, presumably due to hypertrophic cirrhosis, was detected five and a half years ago, and shortly after yellow patches appeared on the eyelids, face, neck, and trunk, striæ on the palms, and papulo-tubercles in the elbow flexures. This *xanthoma* was easily distinguishable from the darkened skin excoriated by scratching for the relief of pruritus. No albumen, no sugar. It was a point of great interest that the woman's symptoms connected with her liver had greatly mitigated, and at the same time the xanthoma streaks and patches had entirely disappeared from the hands and forearms. Dr. Shepherd, of Montreal, had recorded a case in which he had operated successfully for the relief of gall-stone obstruction of the bile duct, and the disseminated xanthoma had completely disappeared.

Portraits of Xanthoma.

Dr. Fox then demonstrated a series of portraits illustrating various cases of xanthoma, and discussed the connection between the more frequent localised xanthoma of the eyelids which sometimes affected families, the xanthoma occurring apart from jaundice or diabetes, which also might occur in families, the xanthoma associated with chronic jaundice, and the papulo-tubercular xanthoma of glycosuria, and discussed the various theories of their causation. Lastly, he dwelt on the exceedingly interesting study of the histological lesions, and the theories of the formation of the characteristic xanthoma cell.

On a Case of Pityriasis Rubra Pilaris.

(Presented by GRAHAM LITTLE, M.D., at Mr. Malcolm Morris's Consultation, February 19th.)

A Case of Pityriasis Rubra Pilaris in a girl aged 6 years. This is so rare a disease that Dr. Crocker, in his text-book published in 1893, states that no case of it had been recorded in England since Tilbury Fox's in 1873; and Dr. Brooke, in *Allbutt's System of Medicine*, states roundly that pityriasis rubra pilaris is unknown in this country. Cases have, however, been shown at the Dermatological Society of

London during the past year, and several are recorded in foreign literature. The first case described of this disease was by Claude Tarral in 1828, at St. Bartholomew's. He regarded it as a form of psoriasis. The next two cases recorded were by Devergie, in Paris, in 1855; he was the first to consider this an independent disease, and named it Pityriasis Pilaris. It is commonly spoken of as the "Maladie de Devergie." Tilbury Fox in 1873 published a clinical lecture on Pityriasis Pilaris; but he regarded the affection as pityriasis rubra, involving the hair follicles, and suggested the name pityriasis rubra pilaris, which is the most widely accepted designation at present. Richaud, in 1877, re-established Devergie's view of the clinical independence of his pityriasis pilaris; and Besnier in 1889 wrote the classical description of it, which remains the most complete study of the disease up to the present day.

The case before you illustrates so admirably all the points of Besnier's monograph that he might have written this from observation of this child. His three cardinal symptoms will at once strike you. These are:—

1. The innumerable small horny, conical, papules limited to the position of the hair follicles, giving to the skin the feeling of a coarse file. Each papule examined with the lens has a central black spot, a truncated hair. A few of the papules taken individually are indistinguishable from those of lichen planus, but if the top of the papule is removed a small central depression is left, quite unlike the papule of lichen when similarly treated.

2. Desquamation of a branny type, with special features on the scalp, where the scales are numerous and enfoliate readily, but do not form the "mountainous heaps" of psoriasis with which they may be confused; and on the palms and soles, in the latter position the epidermis peels very much as in the slighter cases of scarlet fever, and Neumann records a case where the generalised redness and peeling of hands led to a mistaken diagnosis of scarlet fever.

3. Redness, and exaggeration of the folds of the skin. This is especially noticeable in my case about the forehead and neck, but on the whole the redness is a less prominent feature than usual.

Certain other symptoms are added to the above three as frequently present and aiding the diagnosis. Thus the nails, as we see in this

case, are brittle and diseased, dull-looking, and non-transparent; the nail bed may also be affected, and the nails arched laterally, but they are seldom shed. There is a conspicuous tension of the skin of the face which may lead to ectropion, a slight degree of which is present in this case. A feature which is often spoken of as distinctive of this disease is the presence of groups of small miliary, horny, elevations round the hair follicles on the backs of the fingers. These are not well-marked in this case, and are not usually well seen in children, possibly because, as Mr. Pernet suggests, the hair follicles in them are ill developed in these positions. There are often agglutinations of scaly papules forming greenish, greasy-looking "plaques" about the big joints, as here, in front of the knees. The glands in the axillæ and groins are considerably enlarged, although the eruption is not itchy, and there is no excoriation.

The disease has lasted seven months, and the child is said to have lost flesh during the last three months. This is unusual in pityriasis rubra pilaris, which is never fatal, and rarely detrimental to health; but it is the rule in lichen ruber acuminatus, as described by German authors; and it is still a vexed question whether the disease they call by this name is the same which the French school, who think the two diseases are identical, have consistently named "*Pityriasis Rubra Pilaris*."

BY JAMES GALLOWAY, M.D., F.R.C.P.

(*Reported by Neville Wood, M.D., M.R.C.P.*)

CASE I.—*Psoriasis of the Nails.*

MRS. COLE, aged 42, since the age of 18 small patches of psoriasis had occasionally appeared and two are now present on the legs. Six years ago, after an injury, the tip and nail of the left index finger became affected, and subsequently the little finger of the same hand, and the thumb, index, and ring fingers of the right hand. The progress of the disease was typical, an active overgrowth of horny epithelium, commencing at the tips of the fingers, had burrowed under the nail, detaching it from its bed to the extent of about its distal half, and causing thinning and fissuring and loss of its normal convexity. The treatment recommended, which in this case appeared to have arrested the disease, was the removal in layers of the parakeratotic epidermis

by soaking in ligor potessæ, followed by the application of salicylic ointment of 2 to 5 per cent. strength.

CASE II.—*Neurofibromata with Congenital Pigmentation of the Skin.*

On the back of a young man of 26 are numerous tumours the size of a pea, all of them soft and pseudo-fluctuating and having the character of neurofibromata. There was also one of the same size evidently a fibroma molluscum. There is widely-diffused pigmentation of the skin occurring in two forms, patches of considerable size, and many small specks resembling freckles. Sir W. Kynsey and Dr. Neville Wood suggested that the case might be one of Recklinghausen's disease. The patient's intellect, though not actually defective, is dull, and in most respects the condition agrees with the picture drawn by Recklinghausen.

CASE III.—*Lupus Verrucosus in a Girl of 14; Recovery after Curetting.*

The duration of the disease was six years. It had affected the buttocks, thighs, and the left elbow and calf. The treatment had been scraping, followed by the use of the chermocautery and the application of salicylic paste, and in this case with such success that in the smooth scars left there were only a few isolated nodules of recurrence.

Dr. Galloway remarked that this form of lupus shows the greatest tendency to spontaneous cure owing to the down growths of horny epithelium strangulating the tubercular tissue.

CASE IV.—*Lupus Erythematosus.*

The disease, in a young woman of 22, was of four years' standing, and affected the bridge of the nose and nearly the whole of both cheeks. The patches were of a pinkish-purple colour on the cheeks, smooth and shining, and consisted of dilated capillaries with intervening erythema. The nose was rough and scaly, illustrating more the orange-rind or sebaceous type of the disease.

Dr. Galloway considers that apart from minor variations the fact that tubercle bacilli have never been found in the diseased tissue, and that inoculations have always had negative results, proves that this disease is etiologically distinct from lupus vulgaris. He holds that it is rather allied to erythema multiforme, and suggests that it is probably caused

by some persistently acting toxin. The treatment consists in soothing applications in the early stages, followed by painting with phenol.

CASE V.—*Cheirpompholyx*.

The onset of this disease, in a girl of 14, occurred four months previously. Large vesicles had been present on the palms and in the interdigital space. At present there are patches of dermatitis affecting the hands and forearms, suggestive rather of a declining follicular eczema, but on the sides of the fingers are minute elevations, the remains of previously present "sago-grain" granules. The skin of the eyebrows is in a porriginous condition. The treatment recommended is cleansing by saturated solutions of boric acid, followed by the application of zinc ointment.

DISEASES OF THE NOSE, THROAT, AND EAR.

BY HERBERT TILLEY, M.D., F.R.C.P.

(Continued from p. 257.)

CASE IV.—*Woman with Atrophic Rhinitis ("Ozæna")*.

DR. TILLEY demonstrated the curious external appearance of the nose with its tilted tip and somewhat sunken bridge, the atrophy of the intranasal structures, mucous membrane as well as bone, the characteristic smell of the crusts, and the dry condition of the pharynx and larynx, which is often associated with the nasal lesion.

The importance of thorough cleansing of the nose twice daily was dwelt on, and an efficient nasal douche was exhibited and used on the patient. The lotion consisted of a solution containing sod. bicarb. gr. xii, oc. carbol. gr. $1\frac{1}{2}$, sod. chlorid. gr. v, dissolved in a half-pint of lukewarm water. Other treatment is often useful, but persevering cleanliness is more important than them all.

CASE V.—*Chronic Laryngitis*.

CASE VI.—*Nasal Polypus*.

The latter cases were demonstrated and their main clinical features and appropriate treatment discussed.

CASES AND COMMENTS FROM THE SURGICAL CLINIC.

BY JONATHAN HUTCHINSON, LL.D., F.R.S.

(Continued from p. 264.)

XII.—*Supposed Gumma in Tongue.*

IN another case a married man of 30, who denied the history of syphilis, had a large rounded mass in the left side of his tongue, which bulged conspicuously. It was firm but not very hard, quite painless, and free from ulceration. At one spot a small sore seemed to threaten ulceration. In spite of the patient's strong denial I could only believe that the lump was a gumma, and we agreed to test the diagnosis by giving iodide of potassium. There was a broken tooth in the upper jaw just above the lump, but it seemed incredible that it could have induced infiltration into the substance of the tongue without causing a surface sore. The lump was said to have been present about two months, but it had been discovered almost by accident. The patient was brought to us by Dr. Corbett Fletcher.

XIII.—*Case illustrating the Possible Latency of Lupus Germ-Cells.*

On March 8th I produced at our consultation Miss M., a young woman of 29, who had been under my treatment for lupus vulgaris on the tip of her nose eight years ago. After repeated applications of nitric acid the lupus had been absolutely cured, nothing remaining but a thin pale scar. Such was her condition for seven years, during which I never saw her. Recently, however, and in connection in all probability with the cold weather, and with the fact that Miss M. has been obliged to take a situation involving a daily walk in the early morning, two minute spots of lupus growth have appeared at the edge of the scar.

My object in demonstrating this case was to emphasise the fact that the tubercular cell-elements which cause lupus may remain in an absolutely latent condition during a period of many years. I mentioned other similar cases, in which, after cure of a lupus patch by cauterisation, the scar had remained sound for 30 years and then relapsed. It is impossible in such cases to suppose that a new contagion has taken place, for the recurrence is always close to the scar of the original

disease. We can only believe that the bacillus, in symbiotic union with the tissues, may remain without showing any activity until the vitality of the part having been lowered by age, illness, or exposure to local cold, it is able to again manifest its parasitic life.

XIV.—*Hydrocele of Neck.*

A man who was brought by Dr. Macnamara from an establishment where he was exhibited as a Giant was the subject of a large, somewhat pendulous cyst in the lower part of his right neck. The cyst was flaccid, and hung loosely over the inner part of the clavicle. It fluctuated freely, its walls being very thin and loose. It did not extend higher than the middle of the neck. It received a distinct impulse on coughing. It was not in the least painful, and it was only on account of its size that the patient wished to be rid of it.

I expressed the opinion that it was what has been named a hydrocele of the neck, and it was probably of congenital origin. This view I persisted in in spite of the patient's statement that it had formed within the last three years. Having regard to this diagnosis I advised that it should be let alone. These cysts, it was remarked, often pass very deeply, and communicate with others in the mediastinum. To attempt to dissect it out would be attended by risk, and probably followed by disappointment. Very probably some deep portion would have to be left behind, and would be the cause of a permanent fistula.

FISH IN NATAL.—Fish of good quality is abundant in the sea, but is not much taken. The Zulus will not touch fish. Prawns, crayfish, and oysters are obtainable. The fresh-water fish are full of bones. Fine eels and barbel are plentiful in the rivers.

REPORTS OF MEETINGS OF COMMITTEES OF INVESTIGATION.

ON THE CLIMATE, DISEASES, &c., OF SOUTH AFRICA.

THE Committee on the Geographical Distribution of Disease met on Wednesday, March 21st, Sir William Kynsey in the chair. The secretary, Dr. Alfred Hillier, read the minutes of the last meeting, and introduced the topics named at p. 196 of our March number for discussion. A report of the debate will be given in our next.

The following Report on Leprosy in South Africa, which had been drawn up by Mr. Hutchinson, was presented to the Committee. It was ordered to be printed in the Journal for consideration at the next meeting:—

Leprosy in South Africa.

The consideration of the leprosy problem in South Africa presents peculiar attractions, since it is not improbable that, at any rate as far as Cape Colony and the adjacent territories are concerned, it has been developed in connection with the advent of Europeans. That the disease is now prevalent, though only sparingly so, over almost the whole colony, and that it affects individuals of all races, is well established.

The numbers have been counted and set down in statistical tables. It was estimated by Dr. Impey, who wrote in 1895, that there were 600 lepers in Cape Colony proper, 250 in Griqualand East, the same number in Basutoland, and nearly as many in Natal, whilst the Orange Free State had only 150, and the Transvaal Republic only 30.

Whilst these figures must not be taken as more than approximative, they may be allowed to prove that the disease does really exist in all the territories named, and that Dr. Impey's assertion that "the disease is much more prevalent in South Africa than is generally known," may not improbably be true.

Dr. Impey further states as his conclusions—that leprosy has been known in Cape Colony since the middle of the last century, that it is

making increasingly rapid progress, and "that the Hottentots, of whom the Griquas are an offshoot, were, on account of their nomadic nature, the cause of the spread of the disease amongst the Bantu races."

It is with this latter assertion that we have first to deal. Is it probable the Hottentots have had anything to do with the dissemination of leprosy, or with its origination, in this part of the world? And here, of course, a most important inquiry begins, Did leprosy exist amongst them before the Dutch founded Cape Town? A not inconsiderable extent of reading of the Journals of those who have travelled among the Hottentots in the first half of this century leads me to believe that the disease was unknown, excepting in the proximity of Cape Town and some other seaports and fishing towns; and further, that it is still unknown amongst them at a distance from European centres in most of the inland parts of South Africa. An exception must again be here made for the neighbourhood of the large lakes.

Mr. James Backhouse, a Quaker missionary, and a well-informed and very intelligent man, travelled during several years—1840–1843—in South Africa, and as he never stayed long at any one place, he had unusual opportunities for observation as to the condition of the people. Although not a medical man he carried drugs, and very frequently prescribed. His journals give much detail as regards the disease which he encountered amongst the Hottentots and other races, and he never so much as once mentions leprosy. Now leprosy is a chronic and a very conspicuous malady, certain to attract the attention of a quasi-medical traveller like Mr. Backhouse. Dr. Livingstone subsequently for several years resided in the northern part of the district now known as the Transvaal, and subsequently made his famous explorations in yet more northerly districts. He was a medical man, and practised his profession amongst the natives wherever he went. I have been unable to find in his journal, published in 1857, a single reference to leprosy. In his life, which was published subsequently, there does occur an isolated mention of the disease; it was in the neighbourhood of the Victoria Falls. Although we must assume that the diagnosis was correct, it is a very singular circumstance that only a single patient—a chief—is mentioned as suffering from the disease, and that there is not the slightest allusion to its prevalence in the district. The Victoria Falls are in mid-Africa as regards the coast on either side, in latitude 17°, and on a tributary of the Zambesi River.

It is not to be suggested from the silence of Backhouse and Livingstone that leprosy was unknown in Cape Colony in the first half of the present century. It was certainly well known, and already leper establishments had been founded. Its habitats were, however, all near to Cape Town itself, and we may, from the silence of these travellers safely assume that they did not meet with it in more remote parts, and that it was not common anywhere.

I have read also the travels of Christian Frederick Damberger, who in 1801 travelled from the Cape of Good Hope through the colony and northwards, and, as in the case of Backhouse and Livingstone, I find no mention of leprosy. I do, however, get from this author a statement which, in reference to my view of the question, is of great importance, that, even at this early period amongst residents not far from Cape Colony, salt fish was supplied to the Hottentot slaves as an article of food. This, however, he mentions only once or twice, and at all other places records that amongst both Boers and Hottentots he had to be content with milk, meat, and vegetables.*

We will turn next to the facts as regards the earliest observations of leprosy at the Cape. Dr. Inpey tells us that no mention is made of it earlier than the middle of last century, that is about 100 years subsequent to the first formation of a Dutch settlement at Cape Town, and he adds that it is reasonable to conclude that till that time the disease was not prevalent in the European settlement. Although he adds that the disease existed amongst the Hottentots, he does not mention a single fact in proof of it. He assumes, without offering any evidence whatever, that it spread by direct communication from the North. My argument will be that it probably spread in the opposite direction. At the present day, when we have good knowledge as to the diseases common amongst the Hottentots and other races, we know for certain that it is an infrequent malady, and statistics make

* The allusions to fish-eating by this writer are the following :—

P. 37 : “I desired the slaves not to mention my arrival. . . . I ate some rice and fish.”

P. 39 : “I came to the fields of a man named Müllmann, where I met with his slaves and asked them for something to eat ; upon which, two of them gave me their allowance of rice and fish.” The places referred to were within a few days of Cape Town, and it is clear from these expressions that fish and rice were the ordinary food allowed to slaves. It was an inland place, and the fish could be no other than salted.

it very probable that it now prevails in direct proportion with the distance from Cape Town itself. It is the positive assertion of good authorities that until quite recent years it was unknown in the Natal Colony, and, although now Dr. Impey counts some 50 cases, yet many who have lived for long in the colony and have had good opportunities of observation have never heard of the disease.

In conversation with Captain Lugard, an observer who has lived in India and seen much of leprosy, I have been told that during his African travels, which have extended through Cape Colony, but have chiefly concerned inland districts north of the Zambesi, he has never encountered leprosy.

To return to the history of Cape Town. On May 10th, 1756, the local authorities of Stellenbosch reported to the Governor of the Colony that there were cases of leprosy, and asked for instructions as to what was to be done. A special report was drawn up, and it appeared that the victims were two Dutch farmers, and that one of them had then been the subject of the disease for eight years. It was only in two families, and in each instance the father of the family had been the first victim, and although he had continued to live with his wife and sons and daughters, only one other instance of the disease (a daughter) had occurred. In each instance there was a large family.

Dr. Impey very reasonably remarks that the "fuss made over these cases shows clearly that at that time leprosy was not a common disease in the colony," and adds, "probably those two cases were the only lepers in the colony at that time." There is not a hint of any suspicion of its having been contracted from the Hottentots. No further record of proceedings with reference to leprosy occurs in the Cape Colony archives until the beginning of the present century.

In 1817 the Governor of the Colony, then under English rule, Lord Charles Somerset, issued a proclamation that for purposes of isolation the lepers of the district should be sent to Hemel-en-Aarde, a secluded valley in the Caledon district, which had been considered well suited for that purpose. The patients who were sent there were chiefly Hottentots who had, under the Dutch, been slaves. It is stated that at this time the disease was prevalent among the Hottentots, and that for five years previously the Moravian missionaries had been collecting the outcast Hottentot lepers at this spot. Not long afterwards lazarettos were established at Graaff Rienet and Port Elizabeth for the temporary

collection of lepers prior to their being sent to the Home. Let it be clearly borne in mind that all the places named are within comparatively short distances of Cape Town itself.

Between 1816 and 1845 over 400 lepers were admitted at Hemel-en-Aarde. No seclusion was enforced, their residence at this place was voluntary, and they were allowed to have their friends with them. It is clear, therefore, that whatever may have been the opinions prevalent no very cogent fear as regards contagion existed. In the year 1845 the need for additional leper accommodation induced the Government to give up for that purpose part of some old military buildings on Robben Island, which were then occupied by lunatics and convicts. It remained, however, a matter of individual option with patients whether they took advantage of this retreat, and when there no strict isolation was enforced. Ever since the year 1845 the subject of leprosy in Cape Colony has been causing additional anxiety to the Government, since the disease has been observed to be steadily spreading both among white and coloured races. The increase is said to have been greatest near to the Cape itself, and in the Paarl. In 1892 a Leprosy Repression Act was passed, and under it lepers were drafted to Robben Island from various districts, including even some from the Orange Free State and Bechuanaland.

A very important statement is given as regards the Basutos by the late Dr. Cassilis, a medical man who had resided for 30 years in Basutoland, and who averred that the disease was formerly unknown to the natives, and had until recent years been confined to strangers. At present, among the Basutos themselves, there are 250 lepers, and the disease is increasing. So far as I can ascertain, it is not till near the middle of the present century that we get any evidence of the existence of leprosy in the native races. In 1863 it is on record that the Griquas, a branch of the Hottentot race, were suffering from it. The district surgeon of Mount Frere alleges the first discovery of the disease in his part to have been within the last 10 or 15 years. At Umtata it is said to have been introduced 70 years ago. At Ngamatšare it is said to have been imported 22 years ago by a native who had returned from residence in Cape Colony. And it is added that it does not appear to be materially increasing. A number of other places are mentioned by Dr. Impey, in his prize essay, in very similar terms. It would be tedious to mention them, but in all it appears to have been suspected

that it was introduced by the Hottentots. And in all, although there has been some increase, it has been but to a very slight extent.

The conclusion to which the facts just cited would appear to point is that the disease has spread through some change in the habits of the people, probably dietetic, which has been of very slow progress, and which has had its centre of origin at Cape Town. At no single place is it recorded that a violent outbreak, such as might be supposed to result from contagion, has been observed. Although no precautions against the spread of contagion had been taken, and although it must have happened that in all cases the early stages of the disease were overlooked, yet nowhere has anything approaching to an epidemic occurred. An isolated case here and there, lingering long, and followed by a few others in no direct association with it, would appear to be what has happened. Nowhere has any popular alarm as to contagion originated.

Now there is one article of diet concerning which it may be very plausibly alleged that its gradual introduction amongst all classes in Cape Colony has been the cause of the spread of leprosy, and that is salted fish. Early in the history of Cape Town its Dutch founders introduced a number of Malay slaves from their eastern colonies, with the express object of founding a factory for drying fish. That industry has prospered, and is to this day in the hands of the Malays, and salted or dried fish is now an article of consumption wherever it can be conveyed throughout the Colony. Its export in the year 1874 from the whole Colony amounted to 5,000,000 lbs., and was valued at £35,000. At the present time fish is largely caught and dried at other parts of Cape Colony besides Cape Town, notably at Port Elizabeth, which is, as we have seen, one of the places where it has been necessary to found a lazaretto.

If the Hottentots had been the means of spreading the disease, not the slightest explanation is given as to why its spread did not commence much earlier in the history of the Colony, nor why it is not in the present day mainly restricted to them. If, on the other hand, they became its victims, like others in connection with the adoption of a new article of diet, then all is clear. The annals of the country repeatedly record that natives who had left their homes and gone to reside for a time at coast towns came back lepers, and the addition is often made that they were the cause of its spreading (but only to very slight

extent) at their homes. The probable explanation is that they acquired at the towns which they visited a taste for salt fish, and that their return home was coincident with the introduction of that commodity into the district. Many isolated facts may be added to what I have already stated in support of the theory advanced. Thus, Dr. Impey tells us that in Pondoland, a district only quite recently annexed to British dominions, there are no lepers. He adds, what appears to me an entirely gratuitous suggestion, that the chiefs of the country would probably inflict the penalty of death upon all suffering from it. It is far more likely that the exemption is accounted for by the fact that they have not yet begun to import salted fish. Pondoland is situated just south of Natal, and is a district noted for its beauty and for its pasture land.

We may profitably contrast the slow progress of leprosy in South Africa with its very rapid increase in the Sandwich Islands. In both places its advent has been coincident with the formation of a fish-curing establishment, which was a novelty in the district. In the Sandwich Islands, however, this occurred in a small community densely populated, and where a change in dietetic habits, especially the introduction of a new and attractive article of food, would be likely to become very rapidly general. These conditions are otherwise in South Africa, where difference of race, difficulties of transit, and the abundant supply of other articles of food would conspire to make such a change of habit slow and gradual. Salted and dried fish, however, is acceptable to almost all races by whom it is obtainable, and its use under favouring conditions rapidly becomes general. Whilst from its cheapness and abundance it is likely to be consumed in and near the coast towns, where it is manufactured, it is at the same time an article easy of carriage, and certain to command sale wherever it can be taken. We have seen that on the testimony of Damberger it was already, in 1800, an ordinary ration supplied by the Dutch in the neighbourhood of Cape Town to their Hottentot slaves and bastards. It is not going beyond what the facts suggest to hold that the spread of leprosy since that time has been *pari passu* with the advance northward of European settlers and the making of roads. It is to those districts especially where railroads have penetrated that the supply of Cape fish is likely to have been abundant, and, speaking in general terms, I believe that it is chiefly in those districts that leprosy has recently shown itself.

One of the few cases of leprosy from the Cape which has come under my own notice had for its subject a Welshman, who had been engaged in prospecting for a railway, and who told me that salted fish from Cape Town had often been the only kind of animal food which he could obtain.

AMONGST the very few notices of leprosy in the native populations of South Africa, which we have been able to find, is the following :—"Here they saw the first leper, who had lost some of his joints and had the usual leonine expression. They always found lepers in country where the water was bad." These expressions occur in a paper communicated by Major Erskine to the Geographical Society, and founded on a diary, kept by his son, of his travels along the Limpopo River. The statements refer to the mouth of the Limpopo (or Crocodile, the northern boundary of the Transvaal), and, therefore, very near to the sea. No details are given as to the race to which the leper belonged. About the mouth of the Limpopo some of the very lowest of the African races are found. There are also Chobis and other tribes of Kaffirs. No special information is given as to whether fish is eaten, but their canoes are specially praised. It is also incidentally said : "The people here consume numbers of dried caterpillars, which are thought a great luxury."—*R.G.S.*, vol. xix, p. 120.

Mr. Erskine had been travelling from inland and had almost reached the coast when he met with his "first leper." The expression, "they always found them where the water was bad," is vague, and needs elucidation. We must remember that it is not in the words of the traveller himself, but of his father. He mentions that "fish of various kinds abounds in the Limpopo."

From Commander Cameron's work, *Across Africa*, we get the statement that there is a superstition amongst the natives at one spot on the shores of Lake Tanganyika that drinking of the waters of a certain river would in a week or ten days be sufficient to produce leprosy. He adds :—"The inhabitants are certainly leprosy, the greater number having lost a hand or foot, while nearly all are deprived of the sight of one eye and many of both, it being quite a rarity to meet a person not suffering from blindness in some degree. None of the neighbouring tribes intermarry with these people, and when obliged by business to travel through their dreaded country they hurry along as fast as possible. The unfortunate lepers are forbidden to emigrate."

We may gather from this that leprosy is not common in neighbouring districts, and that its prevalence in the tribe referred to has something to do with their peculiar habits, amongst which the food eaten is the one most likely to have been influential. The statement as regards blindness must not be taken as necessarily implying leprosy, for affections of the eye in that disease are somewhat exceptional, whereas ophthalmia from other causes is very common throughout South Africa.

REVIEWS AND NOTICES OF BOOKS.

 DR. ALFORD NICHOLLS ON YAWS.—A CRITICAL REVIEW.

REPORT ON YAWS IN TOBAGO, GRENADA, ST. VINCENT, ST. LUCIA, AND THE LEEWARD ISLANDS. By Dr. Alford Nicholls. *A Blue Book (with Illustrations)*, 1893.

YAWS. By H. A. Alford Nicholls, Dominica, W.I. *Pp.* 45, *with a Bibliography.* (Vol. XVI of Wood's *Twentieth Century Practice of Medicine.*)

Dr. Alford Nicholls is the medical superintendent of the St. Dominica Yaws Hospitals, and has held that post for 20 years. He informs us that he has treated many hundred cases of yaws. He was employed by the Colonial Office to report on the disease as it occurs in the West Indian Islands. He is, therefore, a well-skilled witness as regards those districts, and he has evidently been a zealous observer. It may seem at first sight an act of temerity, almost of presumption, for an English observer to criticise the conclusions of one who has enjoyed opportunities which the latter has not shared. Lookers on, however, sometimes see most of the game. We shall, therefore—in the endeavour to put the important question as to whether yaws is or is not syphilis clearly before our readers—venture to direct attention to much which appears to us weak in his argument. He is a determined advocate of the view that yaws is a distinct malady and easily diagnosed from syphilis by those who are conversant with it.

We will begin by quoting what our readers will, we think, accept as a fairly adequate definition of syphilis. “*Definition*: Syphilis is a specific, contagious, non-infectious disease communicated by actual contact of the virus with a breach of the surface. It is characterised by an incubation period of from ten days to six weeks, followed by an elevation of temperature—which may be slight or may run into continued fever—by rheumatic-like pains in the long bones of the limbs, and by an eruption of squamous patches which develop through a papular stage, and usually terminate without leaving any scars to indicate their sites. The fully-formed eruption has a loathsome

appearance. The disease attacks persons of all races exposed to its contagion, it is rarely fatal, it is chronic in its course, it does not greatly undermine the general health, it may terminate in spontaneous cure, and it is liable to relapse. One attack usually produces immunity from a second one, but the immunity tends to disappear in process of time." We must hasten to apologise alike to Dr. Nicholls and our readers. The above is Dr. Nicholls's definition, not of syphilis, but of yaws, nor have we given it without omissions. We have added nothing, and although the statements omitted were perhaps intended to be distinctive, we cannot think that they really are so. That the main facts are identical as regards syphilis must be tolerably obvious. That the malady should be asserted to be "confined to tropical countries" is no part of a definition, nor probably is the statement that micrococci are found in the diseased tissues of much importance. These two statements, and a third, that the papular stage of the yaws is followed by "distinctive yellow encrusted granulation tumours," are absolutely all that we have omitted. The question seems almost to narrow itself to this, "are the yellow encrusted granulation tumours which disappear without leaving scar" really "*distinctive*" of yaws, or are they not rather a special form of syphilitic eruption? May they not occur in European syphilis, and is not their great frequency in the tropics and in negroes merely a matter of climate and of racial proclivity?

Although in these sentences we have dealt fairly with the whole of our author's definition of Yaws, we have by no means answered all that is alleged in his essays. It will be convenient to take his statements under the three heads of primary stage, secondary eruption, and sequelæ. As regards the primary sore of yaws, Dr. Nicholls differs from all other observers in asserting that there is none, and this, although in his definition he has said that "it is communicated by actual contact of the virus with a breach of the surface of the skin." Other writers have spoken of the "mother-yaw" as the local result of such contact, and have supposed that the usual mode of inoculation was on a previously existing ulcer or abrasion. This creed, which, as is evident, would parallel the mother-yaw with a chancre of the skin, Dr. Nicholls puts aside, and tells us that "cutaneous eruptions in syphilis are secondary forms of the disease, whilst in Yaws the eruption is the primary and only local manifestation." Now the primary sore of yaws has been the

subject of experimental observations. Charlouis inoculated a considerable number of prisoners and produced, after a definite incubation period, a definite local sore and a definite gland enlargement, both which preceded, by some little time, the general eruption. Dr. Nicholls, although he quotes Charlouis in his Bibliography, does not tell us what he thinks of his experiments. To many they appear to be a most valuable contribution to our knowledge of yaws. It is possible that the diagnosis of yaws is rejected, for Dr. Nicholls seems much inclined to doubt whether what has been described by Sir William Kynsey, and others, as Parangi and Yaws in the Eastern world is the same malady as that which he calls yaws. If, however, he puts aside Charlouis' and Kynsey's observations as having been made not on yaws but on syphilis, he practically gives up his case, for both these authors insist strongly upon almost precisely the same facts as his own as constituting the differential diagnosis of their cases. If theirs were syphilis then so also are his own.

The remarks just made apply also to the secondary eruption, for the refusal to admit that the "Parangi" of Ceylon and India is yaws involves the admission that the type of eruption claimed as pathognomic of yaws may occur very frequently and very typically in maladies which are not yaws.

Sir William Kynsey and others who have described parangi, and claimed that it is yaws, have insisted upon precisely the same characters (a framboesial eruption which does not leave scars) which Dr. Nicholls does. They differ only from him in that they admit that it sometimes ulcerates, and is sometimes followed by a sort of serpiginous lupus. Inasmuch as these features bring the disease nearer to syphilis, Dr. Nicholls puts wholly aside the rest of their evidence.

We have ventured to give Dr. Nicholls' general definition of yaws as one which would very well suit syphilis, and we now quote verbatim his description of the skin eruption :—

"The eruption is of three forms, which are now usually designated squamæ, papulæ, and granulomata. They are simply, however, three stages of one eruption, the squama developing into the papula, which in turn becomes the granuloma. But, by abortion, one stage may persist as a distinct eruption, or all three stages may be seen in the same individual at the same time from the commencement to the decline of the disease."

After this is it possible to allege, as a feature of distinction from

syphilis, that the eruption of yaws is not polymorphous? We are next told that—

“The various stages of evolution from the squama to the granuloma are best seen in the early period of the disease.”

And further—

“That the papular stage may persist during the entire period of the disease, or it may appear at any time during its progress. When a general eruption of papulæ reappears as a late symptom the case will be a protracted one.”

The following will probably appear to many to be a good description of syphilitic condylomata, but they really apply to yaws:—

“In isolated granulomata the circular form is most often seen, but at times they are ovoid or reniform, or they may be annular, enclosing sound skin. They are frequently observed about the nostrils, mouth, and anus, where they may implicate the mucous membrane, and in a few cases, as the result of auto-inoculation, these orifices become encircled by a coalescence of contiguous tumours. In such situations, more especially at the anus, the moisture, friction, and muscular movements cause the crusts to be softened and detached, and the granulomata are then either coated with a yellowish-grey viscid exudation, or they present the appearance of pale reddish or pinkish fungoid masses.”

After having put forward the absence of ulceration and of scars as a prominent characteristic of yaws, Dr. Nicholls is obliged to admit that in about 8 per cent. in a hospital in Dominica (into which bad cases were admitted) severe ulcerations did occur, and further, that some writers have described the peculiarities of the “yaws ulcers.” He explains the occurrence of ulceration by supposing that the patients were debilitated, suffering from malarial disease, tuberculosis, or the like; but it is obvious that when the eruption of syphilis ulcerates, which it does perhaps in a yet smaller proportion of cases, the occurrence may be explained by parallel hypotheses.

The duration of the disease may, we are told, vary considerably. It may last weeks, months, or even years. It may occur in successive crops of eruption. It may be attended by fever, and in a certain proportion of cases by slight general adenopathy. Pains in the bones and joints are “a well marked symptom of the disease,” and may be very severe. They are known as “yaws pains.” Relapses may occur, and in the Nevis Hospital no fewer than 18 per cent. of the patients discharged as “cured” were re-admitted after varying periods.

It is difficult to read some of the statements which we have quoted without being reminded of the conclusion of the critic in the Shake-

speare-Bacon controversy who decided that the plays of Shakespeare had not been written by him but by another man of the same name who lived at the same time. So it would appear that yaws is not syphilis but another disease exactly like it. It is to be admitted that there is nothing impossible in the hypothesis that there may be more than one malady of the syphilis type—that is one communicated by contact, having a primary sore and secondary and tertiary stages, all of prolonged duration. It is possible that two such diseases may exist, the stages of which may be almost exactly the same, and the phenomena the same, and yet that the two may be specifically distinct. We have possibly an extant parallel to such a supposed fact in the case of rubeola and German measles. There is, however, a consideration which seems to us fatal to such a supposition. If there were two forms of syphilis specifically distinct, the one from the other, we ought to know them both in Europe as well as in the West Indian Islands and West Africa. The intercourse of our sailors and others, &c., with the yaws-districts is so free that it is certain that if there was a specific contagious malady of this kind they would now and then bring it home. They bring home, as a matter of fact, nothing but ordinary syphilis. In very rare instances what was in that individual case called “yaws” abroad comes to England, but in no instance where this has happened has it been found to be distinguishable from syphilis. It seems absurd to imagine that two different specific forms of syphilis can prevail side by side in the West Indies but that only one of them is susceptible of deportation. We are thus driven to the conclusion that what are claimed as the peculiar features of yaws are due not to difference in virus but to differences in climate and in race.

The citations from Dr. Nicholls' essay which we have given have shown, if we mistake not, that even in his hands it is well nigh impossible to assign any features to yaws which it does not share in common with syphilis, and that for the most part the description of one would apply well to the other. As, however, Dr. Nicholls' observations as to matters of fact do not in all respects tally with those of others, it may be well to cite also the statements of one who wrote without prejudice, and before the heat of controversy was generated.

In Dr. Forbes's *Cyclopædia of Practical Medicine* an able article on yaws appears under date 1835, and from the pen of Dr. W. Kerr. Dr. Kerr apparently entertains no doubt as to there being such a

disease as yaws, and believes that it is distinct syphilis. As to matters of fact, however, we quote from his pages the following, and leave them to our readers' consideration:—

Place of Origin.—Yaws became known to Europeans as an endemic in that part of Africa called "Guinea," and was thence imported into the West Indies.

Primary Sore.—"A specific virus applied to an abraded surface of an individual in whom it has not previously existed." Mode of contagion various, but often by flies, "the minutest quantity of the virus being as potent as larger ones."

Secondary Stage of Constitutional Phenomena.—"Pains in joints and limbs." In some cases eruptive fever pretty smart, in others scarcely discernible. "Eruption at first like pins' heads, but soon increase and become protuberant like pimples," to be followed by red fungi or excrescences, sometimes few and large, in others very numerous and very small. Eruption arrives at its height in a month, but it may be three or four. When excrescences wither, for the most part they leave no scars, but some may continue after others have healed, and may "leave scars like those of cowpox." The patient does not usually lose health, but in some instances, and especially if mercury have been used too early, he may do so, and his disease may become severe and protracted.

Throat and nose "never affected *until after a length of time or improper treatment.*"

All parts of the body may be affected by the eruption, but especially the face, the axillæ, the groins, genitals, &c.

Tertiary Symptoms.—Unless well managed, yaws always attacks the bones. The cartilages of the nose and the palate may be affected.

Degree of Danger.—If judiciously and carefully managed, even under the most formidable appearances, yaws is seldom attended by danger; but, if otherwise, ". . . it is liable to a tedious and dangerous protraction, and often proves fatal under the best directed efforts."

Liability to Relapse.—"In some instances it is to be remembered that, after every appearance of the yaws shall have passed away even for months, and all possible care has been taken of the convalescent, the disease will break out afresh."

Second Attacks.—"The constitution is rendered insusceptible of a second attack." "Dr. Owen, who had considerable experience of the disease, saw only two instances of its second occurrence in the same individuals, and that after an interval of 20 years."

Treatment.—Expectant and local in the early stages; later on, sarsaparilla, guaiacum, &c. "If the disease do not go off kindly, mild mercurials may then, and not till then, be given with safety and advantage." "When erosions of the cartilages of the nose and of the palate, obstinate foul ulcers, bone-aches, &c., have taken place," then "a generous diet and plentiful use of sarsaparilla."

Finally, Dr. Kerr has the following remarkable statements as to the diagnosis of yaws from syphilis, a diagnosis in the possibility of which he was a firm believer:—

"It is true that yaws will affect the bones, the cartilages of the nose, and the palate, like syphilis, and will admit of cure by similar means; but in primary

syphilis neither eruptions nor fungi appear as in yaws, except on the pudenda, and then only in the form of warts. Syphilis will never cease spontaneously like yaws, and, unlike yaws, it may be, and is, contracted repeatedly. Persons who are suffering from yaws may contract gonorrhœa and even syphilis, and it is very remarkable that the former may be cured independently of the yaws, *but the latter not until the yaws have begun to decline.*"

COLLEGE NOTES.

BY THE DEAN.

ONE hundred and fifteen patients presented themselves at the 20 consultations which were held during March. The total number of attendances at the College for the month amounted to 1,037, being an increase of 78 over the attendance for February.

* * *

It has been decided that a course of systematic lectures on Diseases of Children shall be provided for next session. It is gratifying to announce Dr. Still as the lecturer, and it is hoped that his reputation on the subject of pædiatrics will ensure him a large class. Future arrangements will also be made whereby a certain number of consultations will be exclusively devoted to diseases of children.

* * *

THE following scale of Laboratory fees has been approved by the Council:—

				s.	d.
Bacteriological diagnosis of diphtheria	..	..	..	5	0
Widal's test for typhoid fever	..	..	..	5	0
Tubercle bacillus in sputum	..	..	..	2	6
Micro-organisms in blood	..	..	..	6	0
Gonococcus	..	..	..	3	6
Histological examination of new growths	..	..	..	5	0
Parasites of hair and skin	..	..	..	2	6
Microscopic examination of urine	..	..	..	3	0
General qualitative analysis	..	..	..	4	0
Quantitative analysis	..	..	..	7	6

Members are reminded that these fees are applicable to private work only. All necessary laboratory investigations for the elucidation of

cases brought as patients to the consultation-rooms are conducted free of charge.

* * *

THE annual dinner of the Polyclinic will be held at the Trocadero Restaurant on Thursday, May 31st. The Right Honourable Lord Strathcona and Mount Royal has kindly promised to preside. This is an occasion not only for social intercourse among our members, but also for the active manifestation of zeal for the welfare of our Institution. Money is a necessity for our advancing work, and until we are so firmly established that our income exceeds our expenditure, we must, as an Institution, be dependent upon the nurturing care of those who are interested in our growth and development. It is in the power of every member to do something to assist the advancement of the College by—

(A) Coming himself to the dinner.

(B) By bringing with him friends who are interested in our work and may be willing to furnish us with some of the “sinews of war.”

A united effort would at once relieve our Finance Committee from anxiety, and we are firmly convinced that the welfare of our scheme is sufficiently a matter of interest to our members to stir them up to make this year's dinner a success. Dr. Seymour Taylor has kindly undertaken the duties of honorary secretary, and a list of stewards will be published shortly.

* * *

IN response to a widespread expression of Polyclinic opinion, the Council at their last meeting agreed to an important modification of their recent decision as to fees. In future the annual subscription will be two guineas, only to such members of the profession as reside in the London division of *Churchill's Directory*. To all others the subscription will be one guinea as before. Such a modification is obviously a fair concession to the less use which can be made of the College by those residing without the London boundary. Every club has one fee for town and another for country members, and it is on this principle that the Council have wisely acted. The privileges of both classes of members, town or country, will be precisely the same.

* * *

THE next Session of Practical Classes will commence on Monday, May 14th, and terminate on Monday, June 25th. Full details will be,

as usual, previously advertised in the medical journals, or can be obtained on application to the Medical Superintendent. Members who mean to join one or more of these classes will confer a favour both on the lecturers and the executive by giving early intimation of their intention.

* * *

THE first Annual Meeting of the Polyclinic took place on the afternoon of Wednesday, March 28th, and was attended by a fair representation of the members and subscribers. Sir William Broadbent presided, and was supported by many members of Council. There was ample evidence of satisfaction on the part of the members with the work that has already been accomplished. Several suggestions were made by way of improvement on our present methods. Dr. Snape, for example, brought forward an important point by proposing that arrangements should be made whereby *post-mortem* examinations might be attended at some convenient hospital. The Council are fully aware of how desirable such an arrangement is, but there are difficulties in the way which cannot be altogether or at once overcome. The matter is receiving earnest consideration, and it is hoped that ultimately not only the question of attendance at *post-mortem* examinations but the larger question of attendance at the general routine of hospital clinical work may be so arranged as to put it within the power of members of the Polyclinic to have facilities at many, if not most, of our leading hospitals. Mr. Hutchinson spoke with great earnestness in seconding the adoption of the Report, and pointed out what we ought all seriously to take to heart—that if the College is to succeed to the fullest of our anticipations, that success must come from its own vitality. Organisation will do a great deal to make the wheels work smoothly, but it will not inspire those wheels with life. Individual effort on the part of members must supply the motive power.

At a later stage of the proceedings Dr. Snape expressed his opinion that the representation on the Council of general practitioners was too small. He pointed out that as the College was mostly for general practitioners, and would ultimately be mostly supported by them, they ought to have a large voice in the management. This is perfectly true, but it should be remembered that the number of men who either are or have been in general practice now on the Council is greater than perhaps Dr. Snape knows; there are at least eight members of the

Council who have at one time been engaged in general practice, and though some of them are no longer so occupied, surely their value as representatives of the general practitioner is quite as great as if they were still devoted to that line of practice. Another consideration, moreover, that Dr. Snape may not have taken sufficiently into account is this—that the Board of Trade, when granting the Articles of Association, provided for the re-election of the whole Council, the object being that the original Council should continue for a second term of office. According to the Memorandum it will fall to the College, at the next annual meeting, to fill five vacancies, because five members of the present Council must henceforth retire annually. Then will be the time for the members to increase the representation of general practitioners if they see fit, or at any rate to supply the places of those retiring with men who, in their opinion, will adequately fill the position, and energetically promote the interests and efficiency of the College.

Dr. Goodman moved a vote of thanks to the Editor of the Journal, for the efficient way in which his duties were carried out. He commended the Journal as a valuable clinical record which summed up the work of the College, and enabled members whose engagements prevented regularity of attendance to keep themselves *au fait* of the work carried on in the consultation and lecture rooms. He prophesied that when the Journal became known it would, from its own merits, attract a large list of subscribers outside the membership of the College. The vote of thanks, it is needless to say, was carried with acclamation.

* * *

DURING March the Clinical Lectures delivered by Dr. Saundby and Mr. Jonathan Hutchinson each proved attractive to large audiences. It is needless to say that both lectures were handled with skill, and that the subjects of Glycosuria and Syphilis, as respectively portrayed, were masterpieces direct from the hands of the master. Dr. Saundby's lecture dealt too much with case-book details to suit some of his audience, but this was unavoidable from the statistical point of view. Mr. Hutchinson's oration was practical and convincing from beginning to end, more especially in its references to treatment. Clinical lectures such as these are of the greatest importance, and cannot fail to popularise the College, and to bring its practical advantages prominently before those who listen to them.

OUR much respected Chairman of Council, Dr. Miller Ord, has for some time, we regret to say, been far from well. His indisposition compelled him very unwillingly to abstain from delivering his lecture on "The Clinical Relations of Arthritis" on the 11th ultimo. His admirable paper was read by the Dean. The paper dealt comprehensively with most of the leading diagnostic and prognostic points in the differentiation of arthritic affections, and afforded ample evidence of care in preparation and deep insight into the intricacies of the subject. Dr. Ord meditates a long holiday, from which we hope he will return restored to full vigour and activity.

* * *

ARRANGEMENTS are in progress for affording members the privilege of short courses of lectures—not amounting to more than three—on special subjects. The Clinical Lectures now held on alternate Wednesdays are in all respects excellent, but there are subjects which cannot be fully dealt with in the course of one lecture, and there are men who, being master of such a subject, are disinclined to run the risk of impairing the full value of their work and research by unduly curtailing the exposition of their opinions. It is, moreover, the expressed wish of the Council that members should, in this way, be afforded opportunity for giving the College the advantage of special knowledge acquired in pursuance of some particular line of research. Such special courses, on subjects to be announced later, are already promised by Dr. Bowles, Mr. Berry, Dr. Hillier, and Mr. Carless.

* * *

IT is important to call the attention of members to the difficulties which arise when patients do not come to the College till four o'clock. It is necessary always to find out something of the history and main facts of the case before it is presented in the consultation-room, and obviously this can only be managed when the patient comes early enough. Very few cases are accompanied by a detailed description of their illness, and, in order to save the consultant's time, this duty is undertaken by a clinical assistant. It will be a matter of convenience if patients are instructed to reach Chenies Street not later than three o'clock.

* * *

WE record with deep regret the death, in his sixty-ninth year, of Sir William O. Priestley, one of our Vice-Presidents and Parliamentary

representative for the Universities of Edinburgh and St. Andrews. His loss will be much felt, not only in his profession and constituency, but also in the House of Commons, where his opinion on scientific and medical questions was held in universal respect. Sir William was a grand-nephew of the discoverer of oxygen, so that his scientific acumen was both acquired and inherited.

MUSEUM NOTES.

Illustrations of Ichthyosis Herpetiformis or Bielt's Bands.

At p. 41 will be found the description of a case in which a young infant showed curious streaks of brown tint, and slightly papillary, arranged in definite deviation from bilateral symmetry. A peculiar feature in the case was that there were also on one side of the head curved bands upon which the hair was at once thinner and of paler tint. Our Museum will be rich in illustrations of these congenital streaks and bands; showing them on various parts of the limbs and trunk. They are comparatively rare on the scalp, though by no means infrequent on the face. The amount of structural change in the skin of the hands may vary within wide limits. Sometimes, as in the case recently demonstrated in our consultation theatre and to which reference has just been made, they are extremely slight, and in others they may be of very considerable thickness and may implicate various structures of the skin. The essential feature which they have in common is that they are almost invariably more or less one-sided and usually very markedly so.

In further illustration of the case to which we refer we now copy from an American journal a graphic portrait which shows the scalp patches arranged much as in our case, but with much more definite changes. The areas which in our patient were simply marked by softer and paler hair are here seen to be almost bald. The streaks in the neck are correspondingly attended by very considerable thickening, that under the chin especially being so thick and rugose that it might be taken for a thick mole. Differing, however, from common moles the:

patches were definite in streaks, and strictly limited to the right side. Dr. G. T. Jackson, in recording the case, suggests that the patches were distributed by the facial nerve, but in this we can scarcely agree with him. These congenital streaks never follow the distribution of nerves, a fact to which attention has often been drawn. In our Museum collection there will be placed by the side of Dr. Jackson's portrait another published by Dr. Radcliffe Crocker showing almost exactly



Unilateral Papillary Streaks and Baldness (copied by Dr. G. T. Jackson).*

similar distribution of patches on the same parts. There must clearly be some law of development which explains the unilateral location of patches, but what it is we cannot yet state. All that we can allege is that they prove that the two halves of the body have a certain degree of independence as regards their modes of growth.

* *The Journal of Cutaneous and Genito-Urinary Diseases*, Dr. G. T. Jackson, of New York.

In emphasis of the assertion just made that these bands do not follow



the distribution of nerves we give the accompanying illustration, which

shows one running down the entire length of the lower extremity. The original drawing from which this cut has been executed will be found in our Museum. It would tax the ingenuity of the anatomist to suggest any structural explanation of the course taken by this streak.

We append also a figure showing the arrangement of such streaks on



the skin of a person of colour. In this instance the streaks were white. This portrait has been previously published (*see* smaller Atlas, Plate II) with colour, and is copied from a drawing taken by Mr. F. M. Mackenzie in India many years ago.

Portraits of Myxœdema.

The collection of portraits of MYXŒDEMA in the Museum collection includes copies of those published by—

- I. Dr. Ord (two women); *Clinical Soc. Trans.*, vol. xiii.
- II. Dr. Drewitt (three of same woman); *Clinical Soc. Trans.*, vol. xvii.
- III. Dr. Mahomed (a woman); *Clinical Soc. Trans.*, vol. xv.
- IV. Mr. Lunn (a man); *Clinical Soc. Trans.*, vol. xvi.
- V. Dr. Cavafy (three of the same woman at different stages, aged 23, 28, and 33).
- VI. Dr. Savill (a man, aged 45); *Medical Soc. Trans.* (1888), vol. xiii.
- VII. And, lastly, the fine portraits given by Dr. Byrom Bramwell in his clinical illustrations. These latter have been framed.

In addition to those named, we have several old photographs taken before the disease had been recognised, which show in a very remarkable degree the tumefaction of the lower eyelid which often attends this disease. Respecting these, there is some doubt as to whether they illustrate a local form of persistent œdema due to recurrent attacks of eczema-erysipelas or to the constitutional disorder myxœdema. The history of the cases is defective. Dr. Ord, we believe, is inclined to claim them as examples of myxœdema.

If any of our members can supply us with other portraits, we shall value them.

If any of the authors whose names we have mentioned can supply additional particulars concerning the cases which their portraits illustrate, we shall be glad to publish them and to append them to the portraits. The latter will in due course be framed; for the present most of them are in portfolio.

Descriptions of Portraits of Lupus.

In order to assist the labours of the Tuberculosis Committee, which has taken in hand the various forms of disease of the skin believed to be of tuberculosis origin, the portraits of Lupus in the College collection have been classified, and will shortly be displayed in the New Museum.

With them are a number which have been lent for the occasion by various members of the College.

These portraits have been grouped as follows :—

I.—LUPUS ERYTHEMATOSUS.

As typical forms of this species of lupus we have the following :—

- (1) A French portrait showing erythematosus patches symmetrically arranged over the face, forehead, &c., of a young woman. (Dr. A. de Montmèga, Hospital St. Louis.) (“*Scofulide Erythemateuse.*”)
- (2) The portrait, published in the New Sydenham Society’s Atlas, of a delicate lad named Beale, aged 16, in whom the disease had been present one year. It, like the preceding, represents the most purely erythematosus form of the disease. There is a disc on the upper lip, and there were patches in the concha of both ears. No tuberculous history.
- (3) A portrait of Mrs. B., aged 57, showing symmetrical patches of erythema on the face. A peculiar feature in this case is that there are large patches on the chest below the clavicles. This patient has been under observation more than 10 years, and, although the disease has ceased to be aggressive, it is not cured. She is believed to have been the subject of tuberculous disease of the lungs.
- (4) Four portraits of R. H. G., aged 27. In this case, although some patches had occurred on the cheeks, the chief severity of the disease fell on the scalp. It had begun at the age of 16, and had gradually extended to that of 27, when the portraits were taken. One of the portraits shows the patient’s shoulders, which are speckled over with little spots of lupus, clearly associated with the follicles.
- (5) Two portraits of a woman in whom lupus erythematosus occurred on the face and scalp. In this case, as in the preceding one, there was a scattered eruption of acne-lupus spots over the shoulders. They are, perhaps, the first two cases in which this characteristic and very peculiar condition has been observed. It is suggested that it is due to contagion by imbibition from the adjacent patches on the occiput.

- (6) A portrait from Hebra's Atlas showing symmetrical "batswing" patches on the nose and cheeks of a lad. A feature of much interest in this portrait is that it shows very numerous small black comedones at the margins of the spreading lupus patches. It thus illustrates, as do the two preceding portraits, the tendency in lupus erythematosus for the sebaceous follicles to be attacked, and it offers a connecting link with the form which has been named lupus sebaceus.
- (7) The portrait of a man named Cooper showing erosion of the left ear in discontinuous association with a patch of lupus erythematosus on the cheek. His two ears were exactly alike. They had been eroded in early life by a sort of ulcerating chilblain. The erosion commenced at the age of 10, and came to an end in the course of three or four years. The patch on the cheek developed insidiously and without ulceration.

Amongst the exceptional forms is a *sub-group* illustrating

LUPUS SEBACEUS.

These are but few in number, and none of them show well the more characteristic features of the disease, the rugged orange-peel like condition of the skin and the abrupt limitations of the patches.

- (1) A portrait taken from Cazenove's Atlas, and there named "lupus erythemateux." It is probably the first published portrait to which this name was given. It shows the face of a middle-aged man with patches on his nose and cheeks symmetrically placed. There is but little of erythematous congestion, whilst the whole surface is roughened over by the orifices of sebaceous follicles upon which crusts have accumulated.
- (2) A portrait taken from Alibert's Atlas, which has the name of "acne sebacea" given it. There is a well-margined patch on the middle of the nose and another on the right cheek, which shows scar. It may be suitably compared with the next, and both in our modern nosologies, would rank as lupus erythematosus of the sebaceous form.
- (3) A portrait taken from Willis's Atlas, where it is given under the title of "Hypertrophia Folliculorum." It is that of a man of middle age, whose nose is studded over and roughened by plugged sebaceous follicles.

- (4) With some diffidence Hebra's portrait, named "Seborrhea Sicca," is placed in this connection. The nose is involved, and the patches spread symmetrically upon the cheeks. The disease would appear to have been a connecting link between seborrhea and lupus (Heft III, Tafel VIII).

Lupus Erythematosus becoming Generalised over the Limbs and Trunk.

This portrait, copied from one published by Dr. Stephen Mackenzie in the *Clinical Society's Transactions* with full particulars of the case, must stand almost alone. The features of the disease are those of a mixed form of lupus, and in the main probably of lupus erythematosus. The eruption, however, involved almost the entire surface of body and limbs. The patient was a lad of 19, and the lupus had begun on his face at the age of 16. It was restricted to the face for about two years, and then spread to the upper arms, chest, trunk, and finally to the thighs and legs. The hands and feet were but very slightly affected. Everywhere the disease on receding left scars, and it will be seen that the alæ nasi are notched. The patient retained fair health, and there was no definite history of tuberculosis in the family. A sister was the subject of common psoriasis. The mode of spreading in this case was probably by contagion by imbibition, and wholly different from what occurs in multiple lupus vulgaris. It is, however, probably the only case yet described in which lupus erythematosus spread gradually as a chronic malady over all the limbs, and as such is of great importance in illustrating its possibilities.

General Remarks on the Portraits of Lupus Erythematosus.

Attention is particularly asked respecting this series to the following points :—

- (1) That all the patients were youths or adults, no child or senile person has supplied a portrait.
- (2) That in all the face is affected, and that in most it is the only part shown to be involved.
- (3) That bilateral symmetry is usually exact.

- (4) That a very peculiarly florid and thick scar is often left, even in the middle of the otherwise cured patch.
- (5) That no single portrait shows the disease on any part below the level of the bust (Dr. Mackenzie's excepted).

AFRICAN NOTES.

THE following fragmentary extracts have no other bond of connection than that they all relate to Africa. Most of them refer to South Africa, and are of interest in connection with the present course of events. Two or three refer to the West Coast. The letters R.G.S. stand for Royal Geographical Society, from the *Transactions* of which most of the extracts are taken. All that relates to the prevalence of disease in South Africa, whether in human beings or animals, is of special interest in the present juncture. Having reference to the remarkable physical and mental qualities which the Boers have exhibited, we are also bound to receive with attention all information as to their mode of life, habits of diet, &c. :—

To the north, distant some dozen miles or more, were visible the Vliege or Fly Mountains, a range infested by the tsetse or poisonous fly, said to be every year more nearly approaching the inhabited country.—(Magaliesberg), Sanderson, 1851, *R.G.S.*, vol. xxx.

* * *

Near the junction of the Lipalule with the Limpopo, Captain Elton met with the dreaded tsetse on August 19th and 20th. None of his oxen who were bitten experienced any bad effects. He believes that the dangers of the tsetse have been much exaggerated. The natives do not believe it to be fatal unless the animal is in low condition or exposed to rain. A strong healthy animal runs little or no danger.—*R.G.S.*, 1871, vol. xvi.

* * *

Mr. Erskine describing the valley of the Limpopo, the whole of which is of bad repute for fever, writes :—"They now had attacks of fever every 15 days, and had to lay up each time for two or three days. Calomel, Dover's powder emetics, and quinine always proved effectual. Each of them had the fever about 30 times during this journey."—"Erskine's Journey to Umzila"), *R.G.S.*, vol. xix, p. 120.

* * *

The following was the statement of a resident in Mooi River district :—"The country," he says, "is very unhealthy, and he had himself lost 1,200 sheep, 14 horses, and 200 cattle. Fruit thrives, and the baobab, called by them the krematat boom or cream-of-tartar tree, is abundant. The pulp in which the

seeds are embedded is white, of a slight sub-acid taste, and much used to make a drink. He spoke also of a magnetic mountain.”—(Mooi River), Sanderson, *R.G.S.*, vol. xxx.

* * *

Mr. Hutchinson, who published in 1857 a work on Western Africa, where he had resided as Consul eight years, devoted much attention to the prevention and treatment of fever. He especially insisted on flannel next the skin, quinine in small daily doses, and in river expeditions avoidance of stowage of green wood in the bunkers.

* * *

Owing to the distance often from house to house, and the rapid decomposition of dead bodies, the practice of keeping a ready-made coffin on every farm is general, and you may hear a mistress bid her servant fetch this or that, “she will find it in the coffin.”—(The Transvaal), Sanderson, *R.G.S.*, vol. xxx.

* * *

LEPROSY.—Hirsch* does not appear to have been in possession of any facts as to the existence of leprosy amongst the native races of South Africa. He says merely that “it is certain that leprosy is endemic to a very considerable extent at the Cape, the fruitful districts on the east side forming an exception; Natal also is said to be free from the disease.” He further records that in 1858 there were two leper asylums near Cape Town, one inland, “Hemel-en-Aarde,” the other in Robben Island, and that, on the authority of Merensky, a missionary, the disease had occurred amongst the Zulus who had migrated into Natal.

* * *

The plains, as usual, are intersected by little gullies connecting pools. At Alwerses, two hours trek, I left all my horses but two, the country before me having the reputation of being very unhealthy for them. Even here the low grounds only are deemed healthy, while it is said that on the high lands among the thorns they die in numbers. Usually the high grounds are considered most healthy.—(South of the Vaal and near it), Sanderson, 1851, *R.G.S.*, vol. xxx.

* * *

BOER DIET, &c., SIXTY-FIVE YEARS AGO.—We extract the following from *Murray's Geography* (1834):—“*The Dutch farmers*, or boors, of whom grazing forms thus almost the sole occupation, hold very extensive premises, reaching often for several miles in every direction. Yet spacious limits of domains do not prevent frequent boundary-feuds, which are, indeed, fomented by the plan of measuring them, not by the rod and line, but by the pace of an officer employed for that purpose, who is alleged sometimes to measure his strides according to the favour with which he regards the parties. The boor having covered this extensive possession with flocks and herds, resigns himself to supine indolence, devolving the sole labour on his slaves, who are usually Hottentots. He draws from his farm neither wine, fruits, nor vegetables; nor does he make his herds yield milk or butter. The pipe never quits his mouth except to take his *sopié*, or glass of brandy, and to eat three meals of mutton soaked in the fat of the large-tailed sheep. The mistress of the mansion, in like manner, remains almost immovable on her chair,

with hot coffee on a table always before her. The daughters sit round with their hands folded, rather like articles of furniture than youthful and living beings. A teacher is usually employed; but, in addition to his proper functions, he is obliged to employ himself in the most menial offices. Yet they are hospitable in the extreme. A stranger has only to open the door, shake hands with the master, kiss the mistress, seat himself, and he is then completely at home. Those who occupy farms on the borders of the Sneeuwberg, where they are exposed to the depredations of the wild Bosjesmans, acquire, in consequence of the necessity of defending their property, more energetic and active habits."

BOER DIET OF TO-DAY (in camp).—The following extract is from the *Standard*:—"I also learned interesting details regarding the Boer commissariat. Their ordinary rations consisted of a pound and a half of fresh meat daily, and a pound and a half of coffee, three pounds of sugar, and five pounds of flour weekly per man."

ST. HELENA FOR THE BOER PRISONERS.

FROM the health point of view probably no place in the world could be found more suitable than St. Helena for the confinement of our prisoners of war. There is not in the whole island an insalubrious spot. The common English gorse (*Ulex Europæus*), a good judge of climate, grows abundantly. The temperature is remarkably equable, and although the island is so much nearer the equator than is the Cape, it is yet very much cooler. The winters are much warmer than those of England, but the summer heat is rarely so great. The whole of the island is much above the level of the sea and always breezy; even Jamestown, its harbour, is 400 feet, whilst the greater part of the plateau is little under 1,000, and much of it yet higher. The water supply (from 160 wells) is excellent, and almost all kinds of European fruits and vegetables are grown. Should the prisoners desire employment there is much land needing reclamation and abundant scope for gardening. As the island lies on the ocean highway there should be no difficulty in supplying abundance of mutton, coffee, and other Boer necessities.

CORRESPONDENCE AND ANSWERS.

APROPOS of the retirement of Professor Gairdner from the Chair of Medicine in the Glasgow University, the following lines have appeared in the *Glasgow Evening Mail*. They contain some happy descriptive touches, and are worthy of preservation :—

I.

Person of the name of Bill
(For what's Sir William but the gaud
external?),
To you we give the glad hand,
And *Vale* say with tears.
White—
White clear through,
Our truly Grand Old Gairdner, Bill,
Are you.

II.

When now we think of Galen,
Hippocrates his pupil, or Æsculapius,
These sawboneses of old,
We see a gentle soul with peering
spectacles
And whiskers quite perfunctory,
Laughing upon a world he loved
because it ailed
When Air, and Sunshine (sometimes),
Soap, and Water were so cheap.
And ever for you the welfare of your
fellows,
And ever for you the conscientious
task,
And ever for you Progress, and the
eternal Truth,
That in your great Profession
Is a Will-o'-the-Wisp.

III.

Doctors are more deadly than diseases
But yet, but yet,
You found the foetid den, the filthy
warren,
And bade this city ply its besom
When besoms were taboo;
You tracked the noxious microbe to
his kopje,
And nosed for causes of disease zymotic
as if you loved 'em.
They have not yet—alack!—capitu-
lated, but you retirè
Into an honourable inactivity.

IV.

All round the world,
As well as here where best we know you,
And knowing you like you most,
Are fellows you made
To know and honour the craft of
Medicine.
Remembering you, the Master, they
remember
Not the K.C.B.
But Gairdner, the ancient, kind, and
mellow comrade,
A maker of methods,
A maker of Glasgow,
A maker of men.

* * *

AN EARLY REFERENCE TO AFRICAN YAWS.—Dr. Winterbottom, in 1803, wrote on African Medicine. He had held office as physician to Sierra Leone. As a sequel to some remarks on syphilitic affections, he writes :—“Foolas and Mandingos are subject to a disease which they call laanda, which bears a striking resemblance to syphilis, though they consider them as essentially different. The laanda makes its appearance upon the glands or prepuce like a common chancre, but daily spreads, and in time destroys the substance of the flesh. Dangerous hæmorrhages

frequently arise in consequence of erosion, and the disease sometimes affects the throat, destroying the nose and bones of the palate." Here we appear to have an early description of yaws, but who can doubt that it was really phagedænic syphilis? It may possibly interest some to know that the Rev. Sydney Smith reviewed this work in the *Edinburgh Review* for January, 1805. It is from his review that the above quotation is taken.

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M. M. is too late for the "Congress for the Struggle against Tuberculosis under the High Patronage of H.M. the Queen of Italy." It took place in Naples last week.

* * *

C. D.—It is asserted of Cascara as an aperient that it restores tone to the bowel, and that its dose may be diminished after continuous use. Its efficiency in very minute doses in combination with tonics is very remarkable. One or two drops three times a day with nux vomica will often overcome constipation which had previously been very troublesome.

* * *

SAPo, who enquires about antiseptic soaps, may be referred to an able article in the *Bristol Medico-Chirurgical Journal*, September, 1898. The conclusions were that most of the so-called disinfectant soaps are valueless. The writer excepted, however, a soap containing the biniodide of mercury, and known as the "Germicidal soap."

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. II., No. 6.—JUNE, 1900.

MARRIAGE OF FIRST-COUSINS.

AMONGST the many questions upon which it is very desirable that the medical profession should speak with an unanimous voice is that as to the dangers of consanguineous marriages. Although probably there is much less prejudice in this matter amongst medical observers than exists in the mind of the public, yet it is to be feared that a parent seeking skilled advice might easily obtain from two different medical men very confident expressions of opinion in quite opposite directions. Whilst many see nothing of danger in the marriage of cousins, other than the well-known risks of emphasised heredity, others have looming before their imaginations a vision of idiotic and puny offspring as the direct result of what they consider a violation of a law of nature. Now, the facts on this matter have been examined carefully and placed on record with great clearness, and it is surely time that they should be recognised by us all. It is emphatically not the fact that our idiot asylums or our deaf and dumb institutions are disproportionately peopled by the offspring of consanguineous marriages, and it is the fact that many isolated communities in which more or less close intermarriage of relatives has been practised for centuries yet present examples of all that

could be wished in physical vigour. These statements concern general results, and they are subject to certain apparent exceptions, which we shall mention directly. They are intended to imply only that there is nothing connected with the marriages of relatives which necessarily leads towards deterioration. The forces which are at work are simply those of inheritance, and may as certainly conduce to the transmission of sound health and good qualities as to the reverse. There is, of course, in the marriage of first-cousins an increased probability that whatever tendencies may exist in the family will appear in the offspring, since both parents possess them.

It is often supposed that the experience of stock-breeders is adverse to consanguineous marriage, but in reality it has but illustrated the fact just stated. Much of the in-and-in breeding has been carried on with the intention of perpetuating and increasing qualities which were more or less inconsistent with vigorous health. Thus for several generations it may prove very successful, but if too long continued it is found to imperil fecundity or even induce defective development. Most positively may it be asserted that no stock-breeder fears to bring together first-cousins. Many of the marriages which he designedly promotes are incestuous in the highest degree. Yet it is often from such that he obtains the highest class animals, and, we repeat, without the slightest fear of deterioration, if the in-breeding be not too long continued. Now, it is concerning single instances only that the question arises in social life. We are not asked to say what would result if first-cousins should be induced to marry in successive generations, but only in reference to one. Usually it is a father who seeks an opinion and who asks "am I justified in permitting my child to become engaged to a first-cousin?" It is seldom, indeed, that advice is asked concerning any more remote relationships, and it may be said that popular opinion assumes that the marriages of second-cousins are physiologically safe, although forbidden under certain ecclesiastical canons. Now, to a parent making the enquiry suggested, the reply should, we think, be this: "There is nothing likely to be prejudicial to offspring in a consanguineous marriage *per se*, but if there be in your family any definite tendency to such diseases as tuberculosis cancer or insanity, there is a risk that it may be intensified. On the other hand, if your family has a good life-history then there

may be greater security in such a marriage than in one with a stranger whose antecedents may probably be less well known." Even when facts as to disease may be known, we must endeavour to keep well within the bounds of what is reasonable, and not to attempt counsels of perfection. Few, indeed, are those families in which none of the maladies just mentioned are to be found, and in many instances an asserted immunity is simply a denial, in ignorance or otherwise, of the truth. Nothing is easier than in such a case to make a leap from the pan into the fire, and a parent who forbids a first-cousin marriage because an ancestor has been in an asylum or died of cancer must face the responsibility of being not improbably the indirect cause of some yet more risky connection. Assuming that marriage is the natural and much-to-be-desired destiny of most, we must recognise that, as in all other human affairs, a certain amount of uncertainty and risk must attend it. We may seek to minimise the risk, but we cannot possibly wholly avoid it, and too much caution may readily overreach itself.

In asserting roundly that in the marriage of first-cousins there is risk only of the transmission of disease and none as to its creation, it is possible that a little reservation should be made as regards certain rare maladies known as "family diseases." Under this head retinitis pigmentosa probably stands foremost. The facts collected by Liebreich and others have made it seem probable that this malady has been observed with undue frequency in the offspring of such marriages. Respecting other maladies which occur as "family diseases," (that is, to several members of the same family, but without hereditary history), no such suspicion has accrued. Ichthyosis stands as the best type of these, but with it are many others—Friedreich's paralysis, xeroderma pigmentosum, &c. Respecting all these we must believe that something in the assorting of the parents is responsible for their origin, and they are precisely the affections which, if first-cousins' marriage did give tendency to disease, we should expect to result. No facts whatever to favour the belief that they so originate have been recorded. Even as regards retinitis pigmentosa and other affections, when found in the offspring of consanguineous marriages, it is usually clear that they are to be explained on the principles of heredity rather than on the supposition that they are directly due to consanguinity.

As we have already remarked, the traditional creed so commonly entertained by the public, and to a certain extent even by breeders themselves, that it is necessary to avoid in-and-in breeding, is based upon a fallacy. Almost all valuable stocks have originated by careful in-breeding, and their much-valued purity has been maintained by the same means, due care being, of course, taken to eliminate any special weaknesses which may be disclosed. Under such management many special breeds of sheep have maintained their qualities without the slightest failure in fecundity or general vigour through long successions of years. It is only when the object desired by the breeder partakes of the nature of disease that in-and-in breeding becomes prejudicial. Of this pigs offer perhaps the best example. In-and-in breeding of pigs, if too close and too long continued, results in sterility. But what is the explanation? Simply this, that pigs are bred for their fattening qualities, and the tendency to fatten is in itself a disease and is always antagonistic to fecundity. Amongst animals in a state of nature there are certainly no provisions for the prevention of in-and-in breeding, but on the other hand many conditions which favour it, whilst there are no facts which imply ill results from it.

Many persons have doubtless had their prejudices much deepened by the numerous and now widely-known facts as regards the means adopted in the structure of flowers to prevent self-fertilization. These, however, have in reality little or nothing to do with the question of consanguineous marriage. They are expedients for securing the advantages of sex and preventing hermaphroditic reproduction. There exist none whatever for preventing fecundation by closely-related individuals, nor do gardeners, any more than stockbreeders, ever resort to such precautions artificially.

In conclusion we may remark that our argument has not been that in-breeding has no risks, but simply that those risks come under the known laws of heredity and are in no essential relation with consanguinity.

J. H.

THE SURGERY OF THE TUBERCULOUS LUNG.

A CASE of unusual interest in its bearings upon the possibility of surgical treatment of tubercular foci in the lung has just been reported by Ferguson in *The Medical News* (New York, March 17, 1900). The patient—a young negro of 27—came into the Chicago Post Graduate Hospital with a rapidly increasing swelling in his right pectoral region. It had begun as a small lump, but spread until it now reached from the clavicle to below the nipple. There was distinct fluctuation, and as the patient had a cough and night sweats with loss of weight and appetite, there was little doubt as to its tuberculous character. Auscultation showed that the tissue of the lung behind the mass was also involved.

A free incision was made, and the abscess sac, which was found full of curdy pus, was completely dissected out, the expectation being that its cavity would be found to communicate with the interior of the chest.

Nothing deeper, however, was found than osteitis of the third rib, and although the wound healed perfectly, his general condition was rather aggravated than improved by the operation.

After waiting three weeks in the hope of some improvement, it was resolved to attack the pulmonary lesions directly. The pleura was opened, and the anterior aspect of the lung found occupied by a large, hard, unyielding mass, projecting most opposite the fourth and fifth ribs. This was sutured to the chest wall, under the impression that it was an abscess, and left until adhesions had formed. It was then cautiously explored to the depth of three or four inches, but as no pus was found a section was removed from its centre and a drachm of iodoform packed into the bottom of the opening.

This was followed by a surprising improvement in the patient's general condition, his temperature fell from 103° to 97°, respiration from 27 to 20, and he expressed himself as feeling better than he had for months. A week later another drachm of iodoform was introduced into the substance of the tuberculous mass, and this was

repeated some twenty times, covering a period of five months, a new area being chosen for each injection.

By the end of this time the fever had disappeared, the cough ceased, the appetite returned, and the patient had gained 16 lbs., and was walking four or five miles a day.

Various emulsions of iodoform were tried, but the dry powder was found far the least irritating, and this was introduced deeply into the mass through the tube of a small-sized cystoscope. So long as only diseased tissue was penetrated no pain or cough was produced; but furious coughing was set up, accompanied by much pain and shock, when sound lung-tissue was wounded.

Ultimately the entire infiltrated area cleared up completely, and the patient returned to work. Locally the cure was complete, but unfortunately there were other scattered foci in the deeper parts of the lung, and these gave rise to a relapse three or four months later, although the injected area continued perfectly clear. The tuberculous nature of the case was abundantly demonstrated both by examination of excised portions and by the injection of a tubercle-serum, which set up a strong reaction.

This would appear to be a typical result of surgical interference with pulmonary infiltrations or abscesses. The local condition can often be relieved, but unless this is the sole focus of the disease relapses are extremely apt to occur. A little more than a year ago Dr. J. B. Murphy, of Chicago, devised a yet bolder method of attacking the condition of an entire lung by opening the chest-wall, allowing the lung to collapse, and filling the pleural cavity with nitrogen gas, so as to delay its expansion for some five or six weeks. The aim of this procedure was both to put the affected lung completely at rest, and to increase the recuperative and resisting power of the lung-tissue by reducing it practically to a mesh of blood-vessels. We may suspect that neither of them will go far to commend it to the less adventurous mind of the British surgeon, but it is fair to state that encouraging results were reported by Dr. Murphy in a number of cases. Sufficient time had not then elapsed to determine the permanency of the improvement, and further reports are awaited with much interest.

W. H.

PHYSIQUE AND MENTAL WORK.

SOME six years ago it was observed by Dr. W. T. Porter, of St. Louis, after a careful examination of a large number of school children, that bright children weighed more and dull or backward ones less than the average of their age. This has been widely accepted by educators and school physicians, and the revolutionary proposition actually made that children should be graded or classed in school according to their weight instead of according to their age.

On the other hand, the relation is denied by Professor Bous, on the basis of investigations made for him by Dr. G. M. West among the school children of Toronto; indeed, the reverse would seem to be asserted, so that a new contribution to the problem by Dr. Henry Beyer in the February number of the *Journal of the Boston Society of Medical Science* is of much interest.

He was appointed to examine, both physically and mentally, a number of boys who were applicants for positions as navy-yard apprentices, and leaving his colleagues to conduct the mental tests, he carefully recorded the height, weight, and chest circumference of each applicant; then, by comparing each of these with the normal standard for his age, averaging and expressing the result in percentages of 100, so that every unit above fifty represents superiority to the average, and every one below fifty the amount of falling below it, a definite "mark" for physical development was assigned to each boy. This was then compared with his "mark" in the mental examination, and the result may be summed up as follows, the most careful precautions being taken to make the comparison perfectly fair and the markings in both tables fairly representative of the actual mental and physical condition of each boy. Arranging the sixty-one boys in the order of merit according to the mental examination, so that the boy with the highest mark stood at the head of the list and the one with the lowest at the bottom, and then dividing these names into six successive groups of ten, the physical marks of each group were found to exhibit a perfect parallelism with their mental rank.

For instance, the relative physical average for the first ten names was represented by 98, the second ten by 87, the third by 72, the fourth by 62, the fifth by 52, and the last group by 32. By the actual physical marks the average of the first ten, intellectually, exceeded that of the last ten by 45 per cent. in height, 50 per cent. in weight, 38 per cent. in chest circumference, and 25 per cent. in general health.

And not only was their absolute physical development superior, but what might be termed their relative nutrition; for upon calculating their actual weights with the standard which should be attained by individuals of their height and chest circumferences according to Vierordt's formula, the first ten were found to average nearly ten pounds above the expectancy and the fifth ten the same amount below it.

These results would certainly seem to indicate a remarkably close correspondence between the physical and mental development of children, and to support Porter's contention that the latter factor was entitled to much more consideration in the classification of children and the assignment of their school-work than is at present accorded to it.

W. H.

The climate of Ashantee is very unhealthy. Much of the country is forest, and penetrable only on foot or horseback. Coomassie is but very little north of the equator. When, in 1874, Lord Wolseley made his celebrated march, he wisely staid only two days in the capital, but burned it and marched back to the coast. The word Ashantee or Santee means corn-eater, as distinguished from Fantee, an offshoot of the same race, who live on vegetables but have no corn. The corn is, of course, Indian corn or maize.

* * *

LEPROSY IN NEW ZEALAND.—In the course of a discussion at a meeting of the Royal Academy of Medicine of Ireland (February, 1889), Dr. Myles is reported to have said: "There was a small lake in New Zealand around which, even at the time when Captain Cook discovered the islands, leprosy prevailed. The natives attributed the disease to their eating a peculiar kind of fish which was only to be found in that lake. The disease never spread beyond the borders of the lake."

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

THE CLINICAL RELATIONS OF ARTHRITIS.

BY WILLIAM M. ORD, M.D., F.R.C.P.

FROM the diagnostic point of view it is desirable to use the single word "Arthritis" as a common term for all inflammatory alterations of joints. The word is used in this lecture as expressing a condition having, in medical observation, a great variety of forms, a great variety of causes and affinities and, consequently, a great number of involved considerations with regard to treatment. Our patients come to us, at all events in the more chronic forms of arthritis, with a simple statement that they are suffering from rheumatism or chronic rheumatoid arthritis, or in Hospital, with "rheumatics." One joint or many joints may be presented for our inspection. The dominant idea is, certainly in my experience, that the change in the joints is the work of some kind of disorder of the blood, determined either by heredity, by habits, accidents or surroundings. Our patients are more or less gratified whenever we can label a disease with some or other distinctive title. Fortunately they mostly have applied the title already for themselves in the case of arthritis, although there may be many little doubts and difficulties with regard to the word rheumatism or the more aristocratic term, gout. The careful physician must feel that, while rheumatism or gout or any other terms of the kind may be in the patient's mind, the central point for him in investigating the affections of the joints is the local inflammation, single or multiple; conditions involving the whole system or separate parts of it.

The anatomical changes occurring in inflamed joints are, we must remember, far from uniform. We have to recollect that in

arthritis, inflammation of cartilage and the underlying and encompassing bone, of the synovial membrane, of the ligaments and of the surrounding tissues are all concerned, but in such varying forms and proportions as make it no easy matter to depict a type-form.

To take, in the first place, the slow persistent thickening of the joints of the hands and feet, but more particularly of the former, named by Heberden "*digitorum nodi*." The local disorder of nutrition consists chiefly in circumferential thickening of the ends of the bones, in chronic inflammation of the cartilage and ligaments, with comparatively little evidence of affection of the synovial membrane, so far as can be judged from the very limited mobility of the joints under manipulation. But the conditions are very varying in the great number of cases of arthritis affecting, with or without implication of the hands or feet, the larger joints. In a very large class of cases we find a shoulder-joint or elbow or knee greatly swollen, and at some time or another exceedingly painful. In such cases there is, in addition to the circumferential bony outgrowth, a deep affection of the cartilage or cartilages of the joint, leading to wearing away of the cartilages on the opposed joint surfaces, involving the wearing away under the mutual pressure and to exposure of the bone. The bone thus exposed acquires, under the combined effects of friction, pressure and inflammation, a dense ivory-like quality in the immediate confines of the joint, and more or less loses compactness a short distance above and below the joint cavity. With this is presented an important change in the synovial membrane, which becomes thickened, swollen, discoloured, and pours into the cavity a glutinous matter of a coarse kind entirely unlike the just-sufficient and transparent lubricating material belonging to the healthy joint. Like the bone around the joint, the serous membrane within undergoes hypertrophic changes, very much marked where the synovial membrane is applied to the margin of the circumference of the cartilages. Here, villous projections, at first small, are observed to be forming where the synovial membrane constitutes a fold over the edge of the cartilage. Tiny points, smaller than a pin's head, are at first seen, consisting either of a dense connective tissue or of a structure resembling cartilage. In the

progress of this kind of arthritis these little projections are very apt to increase in size and firmness, to push themselves gradually into the joint, acquiring, in succession, the size of peas, beans and grapes. Finally, in progressive cases, these projections are apt to be detached from the synovial membrane and cartilage and to float free in the joint cavity, giving rise often to exceeding pain, and, in many cases, attaining a much larger size so as to interfere mechanically with the movability of the articulation. In such cases as these the ligaments become greatly thickened, and at the same time lose a good deal of their proper restraining and supporting power. What with the wasting of the articular cartilage, the wasting of the bone immediately below it, the loss of resistance by the synovial membrane and the diminution of the support which should be rendered by the ligaments, the whole joint becomes very loose. Thereafter comes a further defect of usefulness in the joints, which is felt more and more strongly in proportion as the rim of new bone round the margin of the joint is imperfectly formed, and weakens a barrier which nature seems in a kindly way to have provided to avoid dislocation. However it may be, there comes a time when we can recognise a distinct tendency to dislocation of the joints, almost always, but with some exceptions, on the flexor side.

For physiological reasons, to discuss which would be out of the province of this lecture, flexor muscles appear to have a force of contraction steadily in excess of that of extensors. If we contemplate a knee-joint advanced in arthritis, we shall find that, in a vast number of cases, the lower end of the femur overrides the front upper end of the tibia often to the extent of inches. In this result, probably the effect of the erect position is to be considered as aggravating the disparity between the contracting power of the two sets of muscles, but, in the hand, where no such pressure necessarily occurs, we can see plainly the excess of flexor over extensor power not only in the aspect of the joints but in the attitude of the fingers, which are, in long-standing cases, seen to be partly dislocated to the flexor or underside of the metacarpo-phalangeal joints, and also uniformly diverted from their proper axial position to the ulnar side away from the thumb. This ulnar deflection varies, and is probably of composite kind, in regard to the muscles affected, and is also extremely typical of what goes on in the joints concerned.

It has to be remembered, however, that the sequence of phenomena is not always such as I have described.

A chronic arthritis may lead, as it does in a great many cases of Heberden's nodes, to ankylosis, and when this is associated with tendonous adhesions, the deformities resulting have a different appearance altogether. Some fingers will be entirely stiff, some strongly flexed, others strongly reflexed or twisted. In such cases, there is usually a strongly marked wasting and induration of all the tissues of the fingers, which is apt to extend to and involve the hand and the wrist. In certain cases of arthritis related with affections of the central nervous system, the process of wasting in the joints is far in excess of the efforts at marginal repair; the rim being only faintly apparent, the texture of the bones above and below the joints is rarefied, an excessive amount of fluid collects in the joint cavity and there follows a remarkable deformity due to loss of cartilage and atrophy of bone, leading to excessive dislocation and, it may be added, to fracture of the bone itself, not due to accident, but simply to failure of cohesion.

We pass to the consideration of the various forms of arthritis, to trace their course, and to sift out their several associations.

(1) We certainly encounter no inconsiderable number of cases of apparently simple or uncomplicated arthritis. These are chiefly to be observed in older persons. I am thinking of cases in which there present themselves to us slow changes in all the joints, chiefly in the hands and feet, and also in the main joints of the limbs, in the vertebral articulations and sometimes in the jaws. They are, for the most part, unattended with pain. The changes in the joints, while comprehending all the primary ones which we have noticed, namely, the affection of the cartilage, of the bone, of the synovial membrane and of the ligaments, are unaccompanied by serious pain or tenderness. They have for their consequence a great deal of deformity, due mainly to the resulting looseness of the joints, and they are steadily progressive. This simple arthritis is just that which may suggest the presence in the blood and tissues of some irritating and widely diffused product of the internal economy. One notable point about them is that while they begin in the later part of life, they are progressive. They cripple the subject by way of increasing helplessness in all movements of the body, yet, so far as

I know, no chemical changes in the blood or tissues have up to the present been detected. They appear to me to be mainly senile changes, to be classed with the change in the colour and falling off of the hair, changes in the gums with falling out of the teeth, with the arcus senilis, and with the other changes that are observed in the eyes as age advances. So far as I am aware, no kind of treatment arrests their progress.

(2) *Arthritis following Acute Rheumatism.*

We have during the last year had two or three cases before us in consultation at this College, presenting a distinct chronic inflammatory affection of the joints, following acute rheumatism. In these we have found the main affection to be of the smaller joints. Our observation noted that the finger joints and the wrist joints had become clumsy and deformed without much pain. I cannot say whether these changes were, in the cases we have seen, progression, or whether they generally are progressive. They form a well-marked class by themselves, and if the term chronic rheumatism is ever to be used it must be applied to them.

(3) In close resemblance with the post-rheumatic changes are those which occur in Raynaud's disease. Here, I must acknowledge, we enter upon a debatable ground. We know, thanks to Raynaud, a great deal about the slow changes in the extremities which mark the progress of this singular ailment. We know how defect of nutrition following upon strangulation of blood-vessels leads to atrophy or gangrene of the extremities of the hands and feet and other projections. Giving the cases careful attention, we may perceive that in most instances there is a distinct change of the articulations, having the appearance of that which is due to a chronic arthritis. The joints are much thickened, they present little indication of fluid distension of the synovial membrane, a good deal of thickening of the bone, and also—a sign of much importance—much pain and tenderness. Raynaud's disease is to be looked at, in one sense, as a definite morbid process, due probably to an original defect of innervation. I may, however, be permitted to suggest to you that there are not only many degrees but many varieties of Raynaud's disease. Short of the

typical form, we have to recognise many minor degrees of asphyxia of the extremities. During both summer and winter one has to examine many cases in which the arterial circulation in the hands is impaired. One sees this in renal disease, in Graves's disease, in heart disease, and in cases of great debility with associated irritability. The hands in such cases are cold to the touch on warm days, are always discoloured in the direction of a terra-cotta tint, the extremities are for the most part swollen, with a strong tendency to the occurrence of chilblains, the arteries can be felt small and closely contracted. In marked cases the hands, when extended, droop under a weight which the extensor muscles cannot sustain, with the consequence of much suffering.

I have several cases under my observation at the present moment, in which these conditions are supposed to be rheumatic. The condition is one of great discomfort, and where the patients are of sufficient means I generally find that they have made a circuit of baths and bath physicians for the relief of so-called rheumatism, which is supposed to be indicated by the state of the joints. To a considerable degree this treatment by baths is rational if the baths selected are those which have a sedative and soothing effect upon the nervous system, and where people can afford the expense and can endure the strain of travelling, baths are among the first things which I would recommend. Short of the help which luxury can provide, these cases lend themselves to the help of drugs. They are much aided by drugs which soothe the nervous system, by tonics of various kinds, and in particular by the use of trinitrin; but it is necessary to emphasise the necessity, in all cases of this kind, of a search into distant conditions of the system which may be at work in producing the contraction of the arteries—affections, that is to say, of the digestive system, of the liver, of the kidneys, and of the female generative organs.

It may be perhaps useful here to draw attention to Heberden's "digitorum nodi." Apart from the symptom of obvious disorder of the circulation, the joint changes in Heberden's disease are very much like those of which we have been speaking, save for the pain and tenderness being much less marked. I advert to them here for a moment partly because of the similarity of the deformity in the two cases, partly because I think that in these nodes the effect

of uterine irritation is suggested in a way that can hardly be explained otherwise than by some relation with uterine disturbance. Heberden, in his original paper published in the early part of the century, summarised thirty-three cases of the *digitorum nodi*, noting particularly the fact that they occurred only in women and in women of middle age. He noticed also the fact that the affection is not commonly very progressive. It touches a point of age beyond which the influence of the sexual system is likely to be much diminished, and, while there is no retrocession of the chronic arthritis, there is no such growing deformity as we observe in most of our cases of arthritis.

I published a few years ago an analysis of thirty-three cases of the nodes, the number being, curiously enough, exactly the number of cases which Heberden analysed. In a large percentage of these I found indications of uterine trouble, particularly of such trouble as is associated with the climacteric. In no case did I detect any serious uterine disease and, so far as my analysis could take me, I found that there was no particular tendency to subsequent affection of the uterine organs. More or less, the uterine troubles and the active affection of the joints die out together.

(To be concluded.)

KEANU AND THE INOCULATION OF LEPROSY.—Dr. Swift, who had Keanu under his charge in the Molokoi Hospital, published his opinion that the man had really the seeds of leprosy in him before the inoculation. He says that the disease developed so rapidly that if it dated from the inoculation it would have been without parallel in his experience.—*B.M.J.*, April 19, 1890.

* * *

CYSTIC oxide has been found in the dog and the hog. It is never amorphous. It appears to replace uric acid and urea, and is very probably the result of some unsuspected article of food, *e.g.*, eggs.

* * *

THE “spider-nævus” may be regarded as a sort of pathological *rete mirabilis*. *Retia mirabilia* are very abundant in whales and some other animals, and may be supposed to exist in a potential sense in connection with the capillary circulation in all mammals.

ON CASES OF MYXŒDEMA, MITRAL STENOSIS FRACTURE OF THE BASE, AND HEMICHOREA.

BY SEYMOUR TAYLOR, M.D., F.R.C.P.

GENTLEMEN,—I here again bring to your notice a patient, the subject of myxœdema, whom you saw last October. Since then she has been under the so-called “thyroid treatment.” You will with difficulty identify her as the same patient, seeing that her œdema of face has disappeared, the hair on the scalp is growing steadily, the skin is less harsh and is more supple, and her voice is musical in quality as compared with what it formerly was.

The only other points I would emphasise are:—(1) That she has been treated by administration of the pure thyroid gland of the sheep in preference to the tabloids; and (2) that there is a tendency to relapse after treatment has been discontinued, especially during the cold season of the year.

Mitral Stenosis.

The next case is one of typical mitral obstruction. It will not delay us long, and I may therefore just point out the principal signs and symptoms by which we come to our diagnosis.

They are as follows:—The apex beat is diffused; there is no great increase of cardiac dulness, except upwards and to the left, over the site of the dilated left auricle; there is a murmur in the diastolic period, beginning in the middle of it and running through to the first sound (middle and last diastolic): this murmur is rough and booming in character, and very local in its distribution, being heard only in a small area represented by a line drawn horizontally inwards from the nipple for two inches; the pulse is small and irregular; and, lastly, she has, on one or two occasions, expectorated blood and has been relieved thereby.

Now, there are two points in this case for our consideration which seem to be antagonistic to each other; they are: does she

require digitalis? and, is the condition of the mitral orifice that of an advanced stage of the disease?

Taking the second question first, I would say that the compensation which you wish to bring about is, or at least has been up to recently, well maintained, since the murmur is such a good loud one. "The drums were very muscular" at the Eatanswill election, because they made a great noise. Similarly I hold with Sir William Broadbent that a loud murmur in most instances means a strong walled cavity behind the disease, and this is what we want. But, on the other hand, the first question is pertinent by reason of the warning which the patient's pulse affords. Its irregularity and occasional intermittent character tells us that sooner or later a course of digitalis and rest in bed will be necessary.

Fractured Base of Skull.

I now show you a young man, aged 33, who fell, some two weeks ago, from a height of about twelve feet, striking on his head.

He was insensible for a time, and when sufficiently recovered, he was brought by his mates to the hospital. On the way thither his somewhat staggering or ataxic gait made his companions think he was under the influence of drink. When I first saw him he had the same symptoms as he presents now, but of course more pronounced.

He had facial palsy on the *left* side, and, in addition, he was completely deaf on *both* sides, whether the sound tests were applied by aerial or by bony conduction. His walk was staggering, but not gyratory. His symptoms are now gradually improving, and we propose to discharge him from the hospital in a short time.

There can be little or no doubt that he has had a fracture of the base, which involved the petrous bone of the left side so as to complicate both seventh (muscles of expression) and eighth (auditory) nerves; but I am at a little loss to quite satisfy my mind as to how the auditory nerve, and no other on the opposite side, has become involved. Is it that hæmorrhage or arachnoid fluid has pressed on this nerve alone, and not the facial? This is possible when one remembers that the auditory nerve, though running

parallel to the facial, is on a plane below it. On the other hand, it has been suggested that his right-sided deafness is due to labyrinthine disturbance caused by the concussion of the fall, either directly or by *contre coup*.

I would, in conclusion, draw your attention to the supposed rareness of recovery in cases of fractured base.

This is, however, the fifth case which has come under my own observation.

Hemichorea.

Here is another case of somewhat uncommon character, viz., a case of chorea in an adult male (aged 21).

I do not care for the word hemichorea, as it appears to suggest a distinct variety of the disease; whereas careful enquiry will elicit the fact, in the vast majority of cases, that chorea begins on one side of the body, and though there should be bilateral convulsions eventually, yet they are strongest on the side originally affected, and linger longer there.

This condition is unusual in an adult male, especially as we can find no personal or family history of rheumatism or of chorea.

I would point out that the jactitations may be and often are so slight as not to be perceived by the eye; but when the patient's hand is grasped in the "shake hand" position and held for a minute or so, small convulsions of the muscles of the forearm and hand may be revealed to the physician in the form of gentle grips or tuggings of his hand.

This I have found a very sure way of detecting cases of mild chorea.

SIR THOMAS BROWNE (*Religio Medici*) lived to be 77, and then died after a short illness from some form of abdominal obstruction. He had presumably enjoyed good health during the later years of his life, for Stukely tells us that his illness was caused by having partaken too freely of a venison feast. His skull and lower jaw are preserved in the Norwich Hospital Museum, and show that he had long been absolutely without teeth.

ON CASES OF RECOVERY FROM LEPROSY.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—I have produced before you to-day an example of recovery from leprosy. I would call it a cured case were it not that I stand in awe of certain captious critics who say that there is no such thing as a cure of leprosy. It is necessary, in their behalf, that we should attempt a degree of precision of language which might otherwise have been needless. We will, then, admit at once that the man before us has permanently lost sensation in his hands, so that he often burns himself by touching things too hot. His feet are also similarly involved, though not quite to the same degree, and in these respects his nervous system has not been, and never will be, restored to a normal state. All evidences of active leprosy have, however, been absent for the last six years. During that period there have been no dusky patches and no aggressive changes of any kind; nor will there, I feel certain, be any relapse. Thus his leprosy is at an end, although some of its consequences remain. Are we—there is still irremediable anæsthesia—to refuse to use the words “recovery” and “cure”? If we refuse them here, I fear we should have to do so also in many other cases in which we habitually employ them. A patient is cured of a rheumatic fever, or has recovered from it, although his heart may be damaged and a joint ankylosed; and although in cases of iritis, adhesions and pigment dots may be left behind, we still record the case as cured when all inflammation has disappeared. In this sense, then, we will, if you please, use the terms “cure” and “recovery” in reference to leprosy, fully understanding that we mean only cessation of the processes of disease, not absolute restoration to a normal condition. There are no other words which we can conveniently employ, and as there is, in many cases, room for debate as to whether or not a cure, in the sense suggested, has or has not been effected, it is well that we should understand from the outset how we intend to employ the word, and thus avoid being engaged in mere logomachy. Not many miles from the Polyclinic there resides a gentleman who was

once a leper. He is now quite blind as the result of his leprosy, and his hands are to some extent helpless from anæsthesia and muscular wasting. No one would, however, take him now for the subject of leprosy. He is a florid, healthy-looking man. His skin shows no trace of tubercle or patch. I have known him for fifteen years or more, and for the last ten he has been as he is now, that is, absolutely free from all aggressive symptoms. Nor will he now ever have any, and I think I am justified in saying that he has recovered from his malady; and if I could credit his recovery to any drug, I should take leave to say that it had "cured" him.

As regards the patient whom we have just seen, I may say that when he first came under my treatment he had well-marked leprosy patches on his forearms and legs. His anæsthesia was much as it is now, and there never was much wasting of muscles and never any conspicuous implication of his face. His ulnar nerves were very definitely enlarged. His hands and feet were dusky from passive congestion, as well as discoloured by the brown patches of leprosy erythema. He had been a soldier and had served many years in India and other places where leprosy is endemic. As usual he was wholly unaware of any special exposure to contagion, and what is of great interest, although by no means without precedent, he never noticed any leprosy patches until he had been eight years home in England. Then they appeared for the first time on his feet and soon afterwards on his hands. The treatment since he has been under my care, that is about ten years, has been small doses of arsenic, as liberal a diet as he could digest, and absolute abstinence from all fish. Under this plan, in about eighteen months all traces of patches had disappeared from his hands and feet. From that time onward his progress has been that of slow restoration with absolute abeyance of symptoms. His hands became less dusky and somewhat less numb; he can now use them well, and they show no very conspicuous changes. They look flabby, and their smaller muscles are somewhat wasted. The nails usually show ridges, and are often more or less ecchymosed, and his fingers are rarely all of them free from plaster or other dressing applied to a burn or other injury. Excepting for these conditions, you would not notice that anything ailed them. His ulnar nerves are much smaller now than they were when I first saw him. I may add that I have repeatedly

produced this patient at Medical Societies, both during his leprosy symptoms and since. He is very grateful for what he calls his "cure," and is always willing to attend anywhere. Excepting dyspepsia, he has of late enjoyed good health.

Let us turn now to the general consideration of recovery from leprosy. In former days it was regarded as an irrecoverable malady, and the object of most leper houses was simply to find the poor sufferer a home until his death, and to prevent his being a source of danger to others. In most no special attempts at treatment were made. Of late years it has been shown by observations in various directions that in not a few cases recovery does take place. These observations have chiefly been made in countries where leprosy is not endemic upon patients who have migrated from the place where the disease was acquired, and have come under wholly altered conditions. As long ago as 1879 I published in the *Medico-Chirurgical Society's Transactions* the case of a woman who had returned from Barbadoes the subject of leprosy in its most severe form—the tubercular. This woman had been in Guy's Hospital under Dr. Addison; and at other public institutions her case had excited much interest. I have never seen the leonine physiognomy more marked than it was in her. In the course of years, however, whilst residing in England all traces of leprosy left her, and when I produced her at the Medico-Chirurgical Society as an example of recovery, excepting that her hands were numb and crippled, she was quite well. I know that she remained in the enjoyment of excellent health for many years afterwards. She herself attributed her cure to a liberal use of port wine which one of her sons supplied her with, and never spoke with much gratitude of what we had attempted to do for her at the hospitals. We had, however, enjoined her to abstain from fish, and this possibly was after all the main agent in her cure. Since then I have seen many cases of lepers coming from abroad to reside in England in whom all symptoms have ceased. Indeed, the cases in which the disease has advanced to a fatal event have been very few. The observation has been made in America that of the Norwegian lepers, not a few of whom find their way into the States, a certain number get quite rid of their symptoms.

From the leper establishments we heard, until very lately, little or nothing as to recoveries. Those who believe in the influence of fish-

diet a cause of leprosy have found nothing astonishing in this fact, since in a majority of cases fish has until quite recent years made an important element in the hospital dietary. When I visited the leper houses of Norway in 1866 fish was supplied for dinner three times a week, and it was not to be wondered at that there we heard of few or no recoveries.

At Robben Island, the leper home for South Africa, fish has never been an article of diet, and although this institution has been by no means a model in other respects, it so happens that it is from it that we receive statements that a considerable proportion of the patients recover. Dr. Impey, the medical superintendent of this establishment, put forward strong statements on this matter, which however, on detailed enquiry, he failed to fully substantiate. Whilst, however, I am obliged to admit that Dr. Impey's facts had been loosely stated, and with some exaggeration, it may still be claimed that they contained an important nucleus of truth. The recoveries had been neither so complete nor so numerous as he represented them, but, still, they had been sufficiently definite and plentiful to establish the statement that in a leper house at no great distance from the patients' homes the disease does not unfrequently show a tendency to cease spontaneously and to allow of restoration to health. It is to be noted that Dr. Impey did not claim anything for treatment, and that, as a fact, no special treatment had been adopted. The agencies in promoting these recoveries must, therefore, have been either lapse of time or change of diet.

It would be easy to multiply facts from various modern sources in support of the belief that the active agent in the evolution of the symptoms of leprosy—that is to say, the bacillus—is an organism which flourishes only under certain conditions, whilst under many others it shows a definite tendency to death.

I need scarcely remind you how closely these facts are similar to those with which we are familiar in the case of tuberculosis. Even in the instance of pulmonary phthisis in its most pronounced forms if the patient can be kept alive, the active process comes to an end, and recovery with damaged organs, as in the cured leper, but still recovery, takes place. In other forms of tuberculosis, lupus, disease of lymphatic glands, joint disease, and the like, it is well known that recovery is common, and that those who may have suffered severely

during several years may yet enjoy immunity and good health during the rest of their lives.

Various hypotheses may be put forward as explanatory of these facts. It may be that the algal parasite, the living presence of which is the immediate cause of tuberculous phenomena, is subject to some law which limits the duration of its life in the same way, though with very different periods of duration, that we know that the life of the specific fever poisons is limited. It may be that the parasite exhausts the pabulum in the blood and tissues of its host, which is necessary for its existence. It may be that it is killed by its own toxine, or by some drug or article of food which has been administered; or, lastly, it may be that it has by some change in the diet of its host been deprived of some element which was necessary to its life. This last is the one which I incline to adopt in the case of leprosy, and the article of food which I suspect is raw fish—salted, dried, or in a state of decomposition.

I have referred to the fact that Dr. Impey, the medical superintendent of Robben Island, made at one time strong statements as to the frequency with which the disease underwent spontaneous arrest or cure. In a Government inquiry at Cape Town much attention was given to this, and medical witnesses were required to state their experience. Amongst others Dr. George Eyre was asked whether the disease, in his opinion, ever underwent spontaneous cure. He mentioned one case. It was that of one of the first patients in the island and was of the anæsthetic form. Pressed as to whether he regarded the disease as “cured” or only “arrested” he prudently replied, “I think the man said that he had had no return of it whatever for thirty years.”

Another witness, Dr. Todd, expressed doubts as to whether the disease can be arrested permanently. To the question, “Suppose the disease were arrested for say ten years?” “That I should call a temporary arrest.” Now if it returned after the end of the ten years the term “temporary” would be applicable, but scarcely so if it had not returned and was not likely to. Dr. Todd subsequently instanced the occurrence of perforating ulcer of the foot in a so-called “cured” case as a proof that the disease was not cured. This, however, is hardly fair, for perforating ulcer is an incident of the anæsthesia and not of the leprosy, and is no proof of the activity of the latter.

Another witness, Dr. J. F. Dixon (formerly medical officer on Robben Island), was asked (2785): "Does the disease ever undergo a spontaneous cure?" He replied, "It becomes arrested in some cases." Asked if he had any record of arrested cases, he said that he had several, and mentioned one in which a man, now aged 95, had had leprosy sixty years ago. He added another in which a man who had lost both legs went about on wooden stumps, but had for many years been free from symptoms. There were also two or three other cases.

Quite recently the Norwegian authorities, who have long taken a foremost part in the investigation of all that concerns leprosy, have supported the doctrine of its spontaneous curability. Dr. Hansen, the discoverer of the bacillus which attends the disease, states that he has seen many cases in which the disease was cured. They were for the most part of the anæsthetic form, but a few were tubercular. In a few the result of *post-mortem* examination had failed to reveal the existence of the bacillus in any viscus, and thus the term "cured" became justified in an especial manner.

If it be asked how it has come about that leprosy, which was formerly regarded as an absolutely incurable disease, is now looked upon so much more hopefully, I would reply that in former times the poor leper had no chance of getting well. The essentials to his recovery are a liberal diet and external comforts, and, according to the creed of some of us, the entire abstinence from uncooked fish. Now, in the olden times the leper was an outcast, and condemned to poverty and the poorest food. If he got access to a leper asylum he would very probably be fed on fish. To a considerable extent this has changed. Our leper establishments allow a more judicious and more liberal diet, and one from which, as in Robben Island, where recoveries have been chiefly claimed, fish is wholly excluded. The best examples of cure have come, however, not from asylums, but from private practice and from cases in which, as in the United States, the patient has migrated to a non-leprosy district and has been able to secure plenty of non-leprosy and anti-bacillary food.

ON BRONCHOCELE AS A FAMILY DISEASE.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—There is a peculiar form of bronchocele which might perhaps be known as the Goitre of Adolescents, and which sometimes affects several brothers and sisters in succession at about the same age. It is not apparently in any connection with endemic goitre, and it usually, I think, disappears spontaneously after a few years. It is sometimes attended by much nervousness and disturbance of general health, but not by the full group of phenomena which make up the type of Graves' disease.

The best example of this family form of bronchocele which I can call to mind came under my notice some years ago, and I feel sure that I have somewhere recorded the particulars, but cannot find a reference. In this instance I saw in succession three or four members of one family, all of whom became the subjects of soft bronchoceles between the period of puberty and adult age. A certain degree of nervous disturbance was very evident in several of them, but in none did it approach that which is usual in "Graves' Malady." In all recovery took place, and the gland receded as adult age advanced. I believe, however, that the gland in most remained permanently somewhat larger than normal, but I am speaking from memory only. Both girls and boys were affected. The family lived in Dalston.

Of this form of goitre we have had two examples at the Polyclinic recently. In the first instance two sisters, one aged 22 and the other 18, had suffered. In the younger a large, soft swelling of the whole of the thyroid was still very obvious, but in the elder, although the gland was still definitely enlarged, it was much less so than it had been some years before. This patient considered herself well, and she came only to accompany her sister. In the latter the swelling was such as to give a conspicuous "full-neck," and was alike in all parts of the gland. In neither of the sisters had there

been any other symptoms of ill-health, and in the elder one the disappearance of the tumour had occurred independently of treatment.

In the second case a girl of 14, well grown, healthy looking, and perhaps rather precocious, was the patient. She had come under Dr. Sequeira's observation on account of urticaria, and he had noticed the bronchocele, which had not been previously observed. As in the other cases the gland was evenly and symmetrically enlarged, and its movement was conspicuous when the girl was told to swallow with the head thrown back. It had caused no inconvenience and was unattended by other indications of exophthalmic goitre. The girl considered herself in excellent health. Her urticaria had affected her limbs chiefly, and had been so pruriginous that she had scratched herself so as to cause several abrasions on her arms and legs. I directed special attention to these little sores, and remarked that it was exceptional for urticaria wheals to resent scratching or to be followed by anything of the nature of sores. Dr. Sequeira told us that he had seen the ordinary wheals of urticaria repeatedly, but none were present when the patient came before us, nor did any very conspicuous streaks result from experimental scratches.

The association of urticaria with bronchocele has, I believe, been noticed by several observers, but it is an open question as to what may be the precise bond of connection between them.

Another case of bronchocele, which has been before us more than once, is perhaps worthy of mention. Its subject is not an adolescent but a married woman who has borne a large family rapidly. She is as yet only 36 years of age and her youngest child is only 18 months old. She is a very vivacious woman, apparently in good health, but complaining of having been over-worked and of having lost flesh of late. The interesting problem in her case is as to what may be the nature of the disturbance which has caused the enlargement of her thyroid gland. The latter is only of quite recent occurrence and is not attended by any prominence of the eyeballs. The gland is, as in the other cases which I have mentioned, only moderately enlarged and is equally involved in all parts. I could find no special indications for treatment and so prescribed merely tonics. Under these the woman improved in strength, and when I last saw her she was again pregnant. Her bronchocele was quite quiet and had, perhaps, somewhat diminished. Although in the cases

which I have mentioned the more severe symptoms of exophthalmic goitre were conspicuously absent, yet I suppose we must consider them as examples of incomplete forms of that malady. This remark probably applies especially to the last case. Examples of what we may call abortive Graves' disease are probably much more common than is the severe type to which we usually restrict that diagnosis. Many persons of both sexes, but especially women, who have never been under treatment for it, yet show very definitely prominence of the eyeballs and a full neck. I have seen these symptoms several times in women who had recently been confined, and have witnessed their almost complete subsidence when their strength was well regained. What the nature of the nervous disturbance is, which in all probability forms the basis of the malady, we cannot as yet define with precision. A clinical feature of much interest is that after having been once well developed and having passed off it is scarcely ever reproduced.

The phenomena of Graves' disease are, if I mistake not, essentially transitory. They may last for many months, or even a year or two, and they may prove fatal, but if the patient survives long enough they pass away in the end, and so far as my own experience goes, they do not, as I have just remarked, ever return. I have seen a good many patients in whom there was the history of such an illness, and in whom as verification the eyeballs remained permanently prominent, a few in whom even blindness had resulted, but in all the nervous symptoms had passed away and the patients had regained fair general health. Now I have never known such a patient to have a second attack, or indeed anything approaching to a severe relapse. It would appear as if the liability to Graves' phenomena was one which the nervous system experienced only once in the life, and that having once overcome it there is little or no risk of its succumbing a second time. As regards the means under which the victory is usually obtained I believe that a complete change of air, scene and occupation is by far the principal. A change to the sea or to mountain air is I think far more influential than any combination of drugs.

It is impossible not to associate Graves' phenomena in some more or less direct way with the generative system. Very rarely indeed are its subjects either children or in advanced life. Usually

they are either adolescents and those in whom the sexual system is in vigour. It occurs in association with both amenorrhœa and pregnancy, and as a temporary condition is not very infrequent after delivery. No one special state of the sex-organs can be alleged as its cause, and yet it remains very probable that it is to the all-powerful disturbing power of this most important part of the human economy that the malady is usually due.

In this connection it is very important that we should recognise minor forms and incompleted cases. It is probable that they are very common, and just as many young persons are more or less hysterical without becoming the victims of pronounced hysteria, so there are many in whom the thyroid enlarges and the eyes become a little full who never develop conditions which would justify the diagnosis of Graves' disease. The examples of adolescent tendency to goitre which I have mentioned, and of which we have had examples before us, acquire additional interest in connection with these speculations.

BASHFULNESS ON EATING.—Cowper's friend, the Rev. Mr. Unwin (jun.), had, from his bashful timidity as to entering an eating-house, gone without his dinner during a visit to London. Cowper rallies him on it, and proceeds: "By the way, is it not possible, that the spareness and slenderness of your person may be owing to the same cause? for surely it is reasonable to suspect that the bashfulness which could prevail against you on so trying an occasion, may be equally prevalent on others. I remember having been told by Colman, that when he once dined with Garrick, he repeatedly pressed him to eat more of a certain dish that he was known to be particularly fond of; Colman as often refused, and at last declared he could not: 'But could not you,' says Garrick, 'if you was in a dark closet by yourself?' The same question might perhaps be put to you, with as much, or more propriety; and therefore I recommend it to you, either to furnish yourself with a little more assurance, or always to eat in the dark."

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AFRICAN.—An excellent paper on the diminution of the rain supply in the Transvaal and adjacent regions is in vol. xxxv. of Royal Geographical Society, by James F. Wilson. He traces it to destruction of trees.

* * *

THE Ainos in Japan are a white-skinned race. They are hairy, and from the circumstance are called "dogs" by the Japanese who regard themselves as much superior. The Ainos are nomadic and are hunters. It is said that they do not eat fish, whilst the Japanese are very fond of it. They have no leprosy, which in some districts of Japan is very prevalent.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY DR. WILLIAM EWART.

April 7, 1900.

Pulmonary Fibrosis or Chronic Pleuritic Effusion?

The case of A. F., aged 20, a slightly delicate, though not "ill"-looking young man, furnishes us with an illustration of some of the early and late results of mechanical injury to the air passages. Several months ago he was brought into St. George's Hospital unconscious and almost suffocated with blood, having been run over across the neck by a cart. Tracheotomy had to be performed on the floor of the ward. I subsequently saw him in consultation with Mr. W. Haward on account of his persistent pyrexia, which I attributed to a pleuro-pneumonia. There was still at that time considerable subcutaneous emphysema, and the percussion note of the sternum was hyper-resonant from mediastinal emphysema. After a while he rapidly improved and left the hospital against advice. His subsequent record is one of chronic cough and expectoration, and of some debility.

With this history of contusive pneumonia the chief possibilities before us are the existence of a chronic pleural effusion or of a chronic pneumonia or phthisis.

General Examination.

The first stage of our examination aims merely at recognising the presence or absence of disease and at identifying any important lesions by inspection and rapid percussion.

Inspection.—We notice the long thin pyramidal neck and the appearance of flatness of the chest. This is often delusive, for Dr. Woods Hutchinson has pointed out that this flatness is often described in phthisis where the thorax is really cylindrical. We also notice the exaggerated S-shaped curve of the clavicles denoting early rickets, the bent upper spine, the stooping attitude of the shoulders, and forward position of the humerus, and the deep infraclavicular fossæ, deeper on the right than on the left. Much of this tends to impede the ventilation of the apex, and is a serious drawback to subjects predisposed to phthisis, and therefore worth noting and correcting by attitude and discipline.

The *respiratory movements*, markedly deficient above, are chiefly abdominal and lower costal. We note that the base of the thorax which is square but not broadened as it is in those, such as bakers and gardeners, whose heavy stooping work paralyses the upper costal respiration. The movements of the left upper chest are not so deficient as those of the right.

Percussion at once reveals almost complete dulness of the right chest, suggestive of extensive consolidation or effusion, and considerable resonance all over the left chest, with obliteration of the absolute cardiac dulness.

Rapid exploration of the apices is best conducted by *bilateral symmetrical direct percussion of the clavicles* alternately by the fingers of the right hand and of the left hand, which was described in the *Clinical Journal* for August 10, 1898. In our patient the right clavicle is decidedly duller than the left.

For the rest of the chest bold strokes are needed. *A single blow at each spot* instead of three or four is best for all concerned, but particularly for the sake of our own clearer perception of the quality of each note struck.

The upshot of this preliminary rapid survey has been to localise the lesion to the right lung.

Special Examination.

The second stage of the examination must demonstrate, if possible, the extent and cause of the abnormal dulness; and in order to

accomplish this rapidly I find it necessary to “localise” the heart, the diaphragm, and the liver.

The heart.—In the twofold difficulty arising from the hyper-inflation of the *left lung* which masks the apex beat and the absolute dulness, and from the dulness of the *right lung*, which tends to obliterate the percussion outline of the right cardiac border, fine percussion will be needed ; but our quickest way to find the position of the apex is to determine by percussion the upper hepatic level which is also the lower level of the heart. This, which is found to be normal, gives us the latitude of the apex, and the line of the left cardiac border, which is now obtained by fine percussion in spite of the hyper-resonant note of the lung, gives us the longitude. The apex must lie at the intersection of these lines ; and since they intersect in an almost normal situation, there is no appreciable displacement of the heart.

The diaphragm.—No great abnormality of level is detected ; but it is seen that the hepatic line is decidedly higher in the right chest than in the left. Posteriorly the lower border of the lung may also be taken as fairly normal, but somewhat lower on the left than on the right side.

The sternal pulmonary border must be determined by fine percussion. For this, as in percussing for the cardiac dulness, I am using the finger first and then the pleximeter. At the upper part the left lung is found to encroach markedly beyond the middle line and beyond the right border of the sternum.

The upper lobe on finer percussion yields dulness above and below the clavicle, and along the clavicle as far as the acromion. The latter, and likewise the head of the humerus, are duller than on the left side. These structures, as well as the outer half of the clavicle, are entirely beyond the region of the lung ; yet their percussion by the alternating bilateral method is most useful in doubtful cases, and especially successful when the outer part of the apex happens to be the seat of the lesion. I can therefore strongly recommend this method as part of the routine examination for phthisis (*cf. Clinical Journal*). The same bilateral immediate percussion is applicable to the spine of the scapula. In this patient, although the supraspinous fossa is dull, and the lower part of the lung is also dull, the spine of the scapula gives a resonant note. Indeed, the scapular

region, with its thick muscular covering, is more resonant than the rest of the chest. The explanation is that the scapula is a huge pleximeter which collects the vibrations from the underlying pulmonary district, which in this instance is rather better inflated than the rest.

All these points have been described elsewhere (*cf. Lancet*, July 2, 1898). Incidentally we note that the vertebral spines are fully resonant; but this is not diagnostic between effusion and consolidation, for it has been pointed out that spinal dulness is not brought about by a unilateral, but only by a bilateral effusion (*loc. cit.*).

On auscultation, the right inner clavicular region yields loud tubular respiration, almost amphoric, and whispering pectoriloquy, which suggest phthisis, and the lower part greatly diminished respiratory murmur and voice sounds. The left lung gives puerile breathing throughout.

On palpation, vocal fremitus is almost imperceptible over the greater part of the right lung, a result consistent with the presence of a slight effusion, or, on the other hand, with the existence of considerable pleural thickening, and therefore inconclusive.

The Differential Diagnosis.

The physical signs which have been enumerated contain the elements of a diagnosis. An additional and crucial test is that of the skodaic resonance. When the lung is compressed upwards, by fluid, towards its tracheal attachment, the boxy resonance of the main bronchus and of its branches is conducted by the condensed pulmonary tissue to the outer manubrial region, or, when sufficient fluid has accumulated to press the lung backwards, to the inner supraspinous region. Only in cases where the pressure of fluid is very great do we find a complete loss of the skodaic resonance at the back as well as in front. In our patient there is dulness both front and back, but since it is obvious that the right pleural sac is not distended, but, on the contrary, reduced in its capacity, the dulness at its summit cannot be due to fluid, whilst the absence of a

skodaic resonance is almost conclusive that there is no appreciable accumulation of fluid at its base.

In conclusion, the diagnosis of phthisis at the apex with fibroid condensation of the remainder of the lung rests upon the following observations :—

- (1) The general aspect and configuration of the chest.
- (2) The presence of chronic cough and expectoration.
- (3) The dulness at the right apex, with cavernous breathing.
- (4) The absence of bulging and the presence of flattening, with impairment of movement.
- (5) The marked encroachment of the left lung into the upper part of the right chest.
- (6) The absence of skodaic resonance.
- (7) The considerable loss throughout the right chest of respiratory murmur and of vocal fremitus without œgophony.

The Prognosis and Treatment.

The affection being unilateral and free from pyrexia, the prognosis is not unfavourable, provided the best treatment—that by open air and abundant food with a suitable amount of exercise—can be secured. Mountain air would be the best, sea air the next best, and country air probably good enough, particularly in summer.

The medicinal indications are in this case limited to tonics and restoratives.

In reply to an enquiry, Dr. Ewart stated his strong belief in the hypophosphites, unfortunately not based upon any pharmacological experiments, but merely upon obvious clinical results. To obtain the latter he thought larger doses were necessary than were generally contained in patent medicines. He usually prescribed together the hypophosphites of calcium, sodium, and iron in equal amounts. His dose for each of them was—for an infant, 1 to 2 grains; for a child, 3 grains; for a youth or a young woman, 5 to 6 grains; for a good-sized man, 10 grains. Other ingredients may be introduced. For instance, the following mixture is at present administered to a neurasthenic farm-labourer at St. George's Hospital :—

R̄	Sodii hypophosp.	...	...	...	gr. x.
	Calcii „	...	...	...	gr. x.
	Ferri „	...	...	...	gr. x.
	Liq. strychn.	...	...	...	℥ v.
	Maltine	...	...	...	3 i.
	Glycer. aurant	...	...	...	3 i.
	Aquam ...	...	...	ad	3 ss.

Ft. mist.

Sig.—One tablespoonful three times daily. To be thoroughly shaken.

In these doses the remedy is of decided use in many conditions besides phthisis. He had found it exceedingly useful in a variety of sweatings, including that of phthisis; the latter, however, usually needs stronger medication. In rickets the great general improvement observed is preceded quite early by a mitigation or a disappearance of the heavy perspirations. He had also found it very useful in checking the heavy sweats of some neurasthenics. In short, the usefulness of the hypophosphites, he believed, might be extended to a variety of conditions of debility.

*Goitre in a Youth without Exophthalmos, but with slight
Tachycardia and slight Albuminuria.*

F. T., a tall youth, aged 17, was sent to me by Mr. Z. Prentice, of Canterbury, where goitre is not endemic (though Dr. E. Blake now informs us that along the North Downs, and especially at Westerham, it is common), for an opinion as to his fitness for the occupation of a clerk. He has always been rather delicate (the lower sternum is deeply depressed), short breasted, and never inclined for athletics.

He is of healthy parentage and aspect, and cannot assign any cause for the goitre, which began about twelve months ago. The trace of albumen observed for some time past by Mr. Prentice has disappeared since his admission into the hospital.

The shape and aspect of the goitre, which was much larger on the right than on the left side, resembles those of the exophthalmic variety. There is a slight fulness of the eye, but no exophthalmos; but I feared that this might supervene, as there is decided though

moderate acceleration of pulse (128 on admission, now 90), and tachycardia generally precedes exophthalmos.

Among the crowd of remedies which tells of our ignorance—the *glandular extracts* (thymus, thyroid, suprarenal), the *tonics* (digitalis and iron, strophanthus, &c.), the *sedatives* (belladonna, opium, &c.), the *alteratives* (arsenic, iodine, &c.), *galvanism* (anode over the cervical spine, cathode over the peripheral nerves, &c.), the *ice-bag* (over the heart, manubrium, or thyroid), and surgically excision of part of the gland, division of the sympathetic chain, or excision of the sympathetic ganglia of the neck—I selected iodine; and he has been taking the following mixture with excellent results:—

R̄	Pot. iod.	...	...	...	...	gr. v.
	R. iodinii	...	...	...	...	℥ vi.
	Sp. amm. arom.	...	...	...	...	℥ x
	Aq. chlorof.	...	...	...	ad	℥ i.

Ft. mist., t.d.s.

The circumference of the goitre, carefully measured by Mr. Powell, has diminished by 3" in a few days; the patient feels better and stronger, is less breathless on exertion, has a slower pulse, and has gained weight.

This bears out Gautier's statement¹ that, with due precautions, iodide of potassium is the best remedy for common goitre, and that it is better tolerated by goitrous children than adults. But it is not always beneficial. We are informed by Gautier and other Swiss physicians that many of their goitrous patients and some women in whom the thyroid disease is latent evince a remarkable intolerance for iodine, the smallest doses of which may bring on aggravated symptoms of "Parry's disease," where they had been previously absent.

Since Parry, of Bath, first described this affection in 1786 (Flajani following in 1800, Graves in 1835, and Basedow in 1840) various suggestive facts have accumulated; but a century of theories has not provided us with the explanation of the nature of the disease.

¹ *Rev. méd. de la Suisse Rom.*, Geneva, 1899; cf. *Edinb. Med. J.*, March, 1900.

Our present theories and their attendant lines of treatment.

Parry's disease is variously regarded as :—

(1) *A pure neurosis*—for the mode of origin is often from shock or fright, and obvious and intense functional nerve disturbances follow.

(2) *A simple hyperplasia* or "*hyperthyrea*" ("*athyrea*" = myxœdema)—for thyroid extract aggravates or may induce the symptoms ; a reduction in size or a partial removal of the tumour relieves them. Greenfield, however, dwells upon the fact that a more mucinous fluid is developed in the hypertrophied gland.

(3) *A disturbed glandular function*, both as regards secretion and excretion and perhaps a perversion of the product secreted—suggested by the influence of iodine and of arsenic, iodo-thyroidism, thyroidism, constitutional iodism, &c.

(4) *An infection by toxins*, probably intestinal—suggested by the gastro-intestinal attacks and intermittent diarrhœas and the improvement from measures antagonising sepsis.

Lastly, *predisposition* is a factor probably in all cases. This is suggested by the frequent occurrence of the affection in members of the same family and by the fact pointed out by Hector Mackenzie, that the thymus is almost always persistent in those suffering from it.

It is not improbable that several of the influences represented in these theories have a share in the pathology of the disorder. The vast array of constitutional symptoms may all be regarded as inevitable consequences of the disorganised special functions of the thyroid gland and of the circulation ; or they may be more closely attributed to a deep-seated nerve disturbance specially affecting the sympathetic. The heart and the thyroid are shown, by the results of operations on the cervical ganglia, to be under some direct sympathetic control, and the gastro-intestinal irradiations special to the disease, as well as the almost universal affection of the nutritive metabolism throughout the body (hair, skin, pigmentation, nerves, cerebrum) point in the same direction. This nerve-disturbance may be primary. It might, however, be secondary to some original intoxication anterior to the special intoxication conditioned by the thyroid itself.

On the other hand, the great clinical facts of artificial thyroidism, of iodo-thyroidism, of the beneficial effects of starving the thyroid or of excising portions of it suggest that thyroid intoxication is an early factor.

Both views might possibly be reconciled by supposing that the same nerve disturbance induces hurry of circulation and an increased production, as well as absorption of the thyreo-globulin or iodine holding globulin (7·6 per cent. iodine) which has been recently identified by Oswald,¹ and to an excess of which in the circulation he attributes the perversion of the metabolism throughout the body.

This conception would suggest the value of a purely symptomatic treatment merely directed to curb the heart hurry, and this is undeniably a useful line of treatment.

Another form of symptomatic and constitutional treatment, that by diminishing wear and tear and supporting the energy whilst removing all adventitious toxic influences, is also reported as highly successful, as, for instance, Mendel's treatment by diet and long hours of sleep (fourteen hours daily).

We cannot speak positively of any truly *causal* treatment; but some of the methods which approach closely to that definition are the *radical* measures addressed to the gland itself and to its secretions, viz., the removal of part of the gland, the ligature of the arteries which supply it with blood, the interruption of the paths of sympathetic innervation to and from the gland, the excision of the cervical ganglion of the sympathetic, the attempt to modify the secretions of the gland by the administration of iodine and of other drugs. All these measures have been tried with varying degrees of success, and that success is consistent, in spite of the apparent diversity of the procedures, with the theory which has been suggested.

As regards the *prognosis* of the patient before us, it is suggested to me by one of our *confrères* that the case is one of "goitre of adolescence" of Hutchinson.² If that view be correct we may look forward to a spontaneous recovery, and that hope is encouraged by the favourable results of the treatment which has been adopted.

¹ Hoppe Seyler's *Zeitsch. für Ph. Chemie*, vol. xxvii., parts 1 and 2.

² See page 367 of current number.

DISEASES OF THE EAR, NOSE, AND THROAT.

BY RICHARD LAKE, F.R.C.S.

The first patient, a girl, 17 years of age, complains of otalgia. It is not constant, but comes on especially at night, and, according to the patient's account, not infrequently keeps her awake all night.

The girl is very anæmic ; there is no history of aural discharge, but there is of otalgia from infancy. The teeth are sound, and a careful examination of the nose, throat, and mouth reveals no possible cause for the pain. The ear partakes in the general anæmic state of the body ; the handle of the malleus is much fore-shortened, the head of the stapes together with the tendon of the stapedius muscle are visible through the much-attenuated membrane, to which the stapes is adherent. There is no doubt as to the fact that there has been at one time an otitis media suppurativa.

The questions that present themselves are chiefly as to the cause. Is it neuralgic, or due in part to the local conditions described ? What course of treatment is to be adopted ? Is there anything to be gained from operative interference ?

Her hearing is much impaired for the speaking voice, and the tuning-fork shows that bone conduction is excellent, so that it is possible that the complete removal of the malleus and the remains of the incus would improve this and relieve the pain at the same time. Such an operation could certainly do little harm, and might result in much benefit, and one would be strongly tempted to try it.

Blistering over the mastoid and iron tonics are suggested ; the latter shall be given further trial, but the former would hardly be likely to benefit much in a case where the anæmia is so marked.

The second case is a *thyroid tumour* in a female aged 34 ; sent by Dr. F. Spicer. This tumour is small and very hard ; it was painful, but painting with iodine has relieved the latter symptoms. It moves with the trachea in swallowing, and causes no other trouble, and is probably an adenoma.

The points to consider are as to the course to adopt. Shall it be removed ?—this with a view to the possibility of enlargement in the future and to the anxiety one might feel as to its nature if it

did so and retained its present hard character. The so-called Indian treatment by inunctions with the red iodide of mercury is often of value in such cases, and will be tried as suggested, although no measure short of removal is likely to get rid of the growth, with its possibilities of malignant development at any moment.

CASE III.—*Empyema of Frontal Sinus after Operation.*

I must first apologise for showing this case, as it does not present much opportunity for discussion, but must plead the difficulty of obtaining suitable cases for demonstration.

This patient, a woman aged 56, had suffered for some time with nasal polypi and nasal discharge purulent in character. She has had her maxillary antrum on the same side (the left) treated by operation, without much relief, and for the last three years has suffered with constant frontal and occipital headache. The disease of the sinus was very extensive, as will be seen by the incision, which has been kept below the eyebrow, hoping that by this measure the scar will be less visible, as when the cut is made through the eyebrow itself the hair often fails to grow at the line of incision.

The headache has entirely ceased since the operation, and I would draw attention to the occipital headache, which, though common in other conditions, is certainly very rare in this; I do not remember having seen it mentioned. In connection with this disease I should like to allude to a mode of treatment I adopted in a recent case and the reason that induced me to do so. In examining the so-called polypi or granulation tissue removed from the frontal sinus I was struck with the fact, as it appeared to me, that the epithelium was never broken in any instance that I could find, other than by the instrument used in its removal; and it seemed probable that if the sinus was efficiently drained after careful cleansing, that the infiltration in the muco-periosteal lining would organise, and that one would thereby obtain a more rapid cure, and that with a smaller scar.

My patient was nice-looking, which made me more anxious to minimise the scarring as far as possible. The greater rapidity of healing would be due to the fact that there would no longer be the

long period lost whilst the epithelium gradually spread from the infundibulum over the large denuded surface. This case gives promise of that rapid result. A drainage tube was passed down into the nostril and is still in position, but can be readily removed and replaced by the patient.

Syphilitic Disease of the Nose.

The patient, a woman 47 years of age, also sent by Dr. F. Spicer, presents herself for treatment; she has a swelling, on the outer aspect of the nose, of two years' duration. It is situated at the lower extremity of the nasal bones, is very hard, and painless in the centre; at the sides, on the contrary, it is soft and tender. The skin over the swelling is red and of a dusky hue, and is desquamating.

The right side of the interior of the nose shows a hypertrophic state of the mucous membrane very suggestive of syphilis; the left side shows a swelling on the septum, that, commencing low down, proceeds upwards to the region of the external mass; on this swelling one sees two small ulcers oval in shape. Dr. Purdy points out that the posterior pillar of the fauces on the right side is adherent to the posterior wall of the pharynx. There is also a small perforation of the septum.

Her history indicates a probable syphilitic infection, and she is improving under appropriate treatment.

The external swelling, at first sight, almost resembles a chronic furuncular condition, but the enlargement is firm and apparently cartilaginous in the centre, probably a gummatous growth of the septal cartilage.

DISEASES OF THE SKIN.

BY DR. WHITFIELD.

Papular Syphilide resembling Lupus.

A case sent up by Dr. Rankin. The patient was a married woman suffering from numerous patches of red, scaly, papular eruption occurring on the shoulders, arms, face and head. The patches were all similar in type, but varied in size, being as large

as the palm of the hand on the arms and shoulders, while on the face the disease was limited to the area round the mouth and the alæ nasi. The type of eruption was a large, deeply-seated, red papule, covered with a scale and offering a sense of infiltration to the touch. On pressing out the congestive redness a slight yellowish, transparent stain was left, showing that there was cellular infiltration of the corium. The tendency of the eruption was to a centrifugal spread with central resolution, and where this had occurred there was left behind a fine scar or atrophy of the skin, partly white and partly brown from pigment.

There were numerous ovoid and circular scars on the extremities which the patient stated were left by an eruption resembling vaccination, and which occurred nineteen months before. The patient had two children, with one of which she was pregnant at the onset of the first eruption, and one which was born since that time. Both of these children were, and had always been, healthy. Dr. Whitfield pointed out that the facts helping in the diagnosis were: The presence of a scar-leaving eruption, the presence of marked infiltration in some of the papules, the fact that the scar when once formed remained sound, a fact which was seldom found in lupus vulgaris. He considered that the eruption was one of late papular syphilis, and remarked that the eruption of nineteen months previously was in all probability rupia. As regards the birth of healthy children, he said that this might have been due either to successful treatment, or some factor with which we were still unacquainted, but at all events it was far from uncommon.

CASE II.—*Hebra's Prurigo in a lad of 17.*

This eruption showed all the points that were characteristic of the disease, namely, the pale, anæmic, hard papule, the marked stiffening of the skin, pigmentation, and the associated indolent swelling of the glands. Dr. Whitfield showed photographs of the boy when first seen, pointing out how impetiginous lesions were engrafted on the original condition, owing to the scratching of the patient. The disease had commenced at the age of 8, and he had been unable to get any history of a previous lichen urticatus, such as was often stated to be the case. The eruption was getting

gradually well and now only came on in the cold weather. Great improvement had been observed under treatment with strong tar ointments.

CASE III.—*Lupus Erythematosus affecting the nose, one cheek, and the upper lip.*

This case was one of nine years' duration, and was of the very chronic, slowly progressing type. The white scales were a very marked feature, and the case would therefore be classed as the sebaceous type by some. In discussing the treatment of the disease, Dr. Whitfield said that opinion had come round of late years towards the palliative methods, and dermatologists now seldom recommended scarification or caustic treatment.

With this he was almost entirely in agreement, and said that if vigorous measures were to be undertaken at all they should only be used in mild weather, since either a cold wind or a blazing sun always made the disease more irritable. He had seen some very good results from the cautious use of weak pyrogallic acid ointment, but they required very careful watching, and it was always advisable to err on the side of doing too little rather than too much.

CASE IV.—*A Peculiar Dystrophy of the nails associated with Lichen Spinulosus of the buttocks.*

The nails, which were affected more or less symmetrically, though two fingers were spared on the left hand, showed a progressive atrophy of the matrix. The free edge was comparatively firm in consistency, but showed a strong tendency to longitudinal fissuring. As one passed the finger further backwards towards the root of the nail, one found that it became progressively more ribbed longitudinally and also thinner and softer in consistency until, at the posterior nail fold, it was scarcely harder than ordinary epidermis. The condition had existed about a year, and its cause was unknown.

The lichen spinulosus occurred in typical patches of grouped papules over the buttocks and thighs on both sides, affecting more

especially the left. Each hair follicle was the seat of a short, dark, epidermic horn, which gave rise to considerable itching at times. Inflammation round these was slight, or absent, except where scratching had caused some pustulation. Dr. Whitfield discussed the diagnosis, and said that the other diseases bearing some resemblance to it were pityriasis rubra pilaris, lichen scrofulosorum and lichen pilaris.

OPHTHALMOLOGICAL.

BY E. TREACHER COLLINS, F.R.C.S.

CASE I.—*Congenital Ectopia Pupillæ and Ectopia Lentis.*

Sarah C., aged 22, had always had defective sight. In the right eye the pupil was displaced upwards and outwards; it acted to light and dilated with atropine. The iris was slightly tremulous. By oblique illumination and by reflected light the edge of the lens could be distinctly seen passing across the centre of the pupil, the lens being displaced downwards and inwards. The fundus could be seen ophthalmoscopically, either through the displaced lens, or through the aphakic area. A prismatic effect could also be produced by looking partly through the edge of the lens and partly through the aphakic area, so that the optic disc was seen double. No fibres of the suspensory ligament were seen stretching across the aphakic part.

$$V = \frac{6}{36} \text{ 1 letter, } c + 4 = \frac{6}{24}. \quad J \text{ 12.}$$

In the left eye there was a similar displacement of the pupil up and out, and of the lens down and in, but the displacement of the latter was more marked, so that only just its upper and outer margin could be seen in the pupil. The iris was more markedly tremulous than in the other eye. No fibres of the suspensory ligament were to be seen. V. = to counting fingers only; unimproved with any glass. A younger sister of the patient has a similar displacement of the pupils and lenses, also some persistent remains of the pupillary membranes.

CASE II.—*Traumatic Dislocation of Lens.*

To compare with the foregoing, this case is of interest. A man of 65 was struck in the left eye by the fist of a drunken companion some five years ago. The accident was followed by a good deal of pain and some loss of vision, and upon examination the lens was found displaced downward and backward. The iris quivers at every movement of the eye; the pupil is small, round, and movable though sluggish. By patient use of the ophthalmoscope the edge of the shrunken lens may be seen to float up across the lower part of the pupil.

His vision is reduced to a bare perception of the movements of the hand, and, as his right eye shows a distinct stage of incipient cataract, his ability to find his way about is somewhat impaired.

In spite of serious impairment of vision, no operative interference is advisable in his left eye, as, although the lens might be removed, a large amount of vitreous would be almost certain to escape during the process. The rule in these cases is to avoid operation unless rise of tension and persistent pain occur, when an attempt must be made to extract the lens or to perform iridectomy for the relief of tension.

The removal of the lens must be done with a scoop, through a large sclero-corneal incision, and it may be worth while to endeavour to get the lens into the anterior chamber before operating and then to hold it there by contracting the pupil behind it with eserine.

CASE III.—*Congenital Anterior Polar Cataract.*

The patient, a girl of 16, complains of the disfiguring effect of a "white spot" in her right eye. This is most obvious even at a glance, and upon closer inspection it is found to be a white cone-shaped mass which occupies the centre of the pupil and projects so boldly out into the anterior chamber as to give one the impression of almost touching the cornea. By looking closer a broader and grayer basal portion can be made out deeper in the lens substance.

The patient says that the spot has been present ever since she can remember, and while the commonest cause of this defect is a penetrating ulcer of the cornea in infancy with affection of the

anterior pole of the lens, there is no such history here, and the condition is probably congenital. In such a case it is probably due to an error of development, the cornea and lens failing to separate properly as the eye grows, and proliferation of the capsule cells taking place between their contiguous surfaces.

She is anxious to have the disfigurement removed if possible, and if this is interfering with her securing occupation, or having any serious cosmetic effect, a free needling operation can easily be done. As far as the improvement of the vision is concerned it is usually not advisable to interfere in these cases (*i.e.*, cases of monocular cataract), as, to get any clear perception of outlines, a lens, of course, must be worn, and this is of such strength that patients almost invariably complain that the two eyes will not "work together" comfortably and refuse to wear the glasses.

On the other hand, however, if the cataract is large enough to occupy pretty much the whole of the pupil when moderately contracted, and so to produce serious defect of vision, the mere restoration of perception of moving objects on the affected side and increase of the field of vision may be of sufficient value to warrant an operation, particularly in 'bus or cab drivers, carmen, or others whose occupation demands a sharp look-out upon all sides.

In a few fortunate cases of anterior polar cataract the opaque part is so completely external to the lens that it drops right off into the anterior chamber at the first touch of the needle; but opacity in this case, as has been seen, extends obviously more deeply, and any attempt to detach it would open the capsule and admit the aqueous to the substance of the lens.

REVIEWS AND NOTICES OF BOOKS.

- I.—THE CAPE OF GOOD HOPE LEPROSY COMMISSION, 1894. *Minutes of Evidence*, vol. i., a Blue Book, pp. 601. Cape Town.
- II.—THE SAME. INTERIM REPORT OF COMMISSIONERS. *Minutes of Proceedings and Appendix*, vol. ii.
- III.—THE SAME. *Abstract of Replies to Interrogations; Correspondence; Acts relating to Leprosy, &c.*, vol. iii.
- IV.—THE SAME. FINAL REPORT OF COMMISSION. *Minutes of Proceedings and Appendix*, vol. iv.

We have before us four somewhat voluminous Blue Books, the result of the labours of a Commission, consisting of five medical men, which sat in Cape Town from February 5, 1894. These volumes, in addition to a mass of matter of only local and temporary interest, contain incidentally the most modern epitome of information in reference to leprosy which we possess. Their date is subsequent to the issue of the *Report of the Indian Commission* and the conclusion of the *Leprosy Journal*, and the facts contained in these are freely quoted. The subject of leprosy has been taken up in the Polyclinic by a Standing Committee upon that special subject, and it has also presented itself prominently to the attention of another Standing Committee which is at present investigating the diseases of South Africa. Cape Colony indeed offers exceptionally good opportunities for the examination as to the causes and mode of dissemination of this malady, since in many parts it is of quite recent introduction and limited incidence. Here, if anywhere, we ought to be able to solve the questions just referred to. Here, also, we shall have the best opportunity for estimating the efficiency of segregation methods in preventing its spread. In our last number we gave a Report which had been presented to one of our Committees, which briefly summarised the principal facts. With the view of still further assisting our Committee and in the hope also of exciting the general interest of our readers in a most important international subject, we now offer some selected

extracts from the reports before us. In doing this we shall introduce but few comments of our own, but leave the facts and statements to produce their own impression.

The first asylum for lepers in Cape Colony was begun in 1817, and was situated in a valley to the east of Cape Town.

Hemel en Aarde—the first Leper Home in South Africa.

DR. JOHN MURRAY in 1822 wrote respecting the asylum near Caledon : “This institution, which has got the name of Hemel en Aarde (Heaven and Earth), was formed as a Colonial charity only about five years ago, although for a long time previously Hottentots affected with leprosy were put under quarantine in huts in this detached place, and supported by funds raised in the Swellendam District where the scattered races of aborigines had been collected by missionary people. The disease is confined chiefly to Hottentots. In the above-mentioned institution, containing about 150 persons, there are not more than two white women and three or four Mozambique slaves. There is reason to suppose that it has long existed among the Hottentots, although it does not seem to have been properly brought to light till after these people were congregated by the missionaries.”

“At the institution here are a great many not affected with the disease (about one-third of the whole), consisting of the parents, husbands, wives, and children of those labouring under it who have followed as attendants ; and by this means an opportunity has been afforded of proving that the disease is not contagious, as I am informed by the medical practitioner who was lately attached to the institution that it has not been communicated to any of these attendants.”

In 1853 after this location had been given up a Commission was appointed to enquire as to the disease in the Colony, and from the evidence given at this date the following extracts are made :—

Dr. Laing told the Commission :—

“Hemel en Aarde, which is at a distance from Caledon Baths, though expressly appropriated and intended for lepers, was also a refuge for sick and destitute Hottentots. Though meant as an asylum for lepers, they were under no quarantine and were visited by their friends.”

We may remark that there is little doubt that the above statement would apply to every leper house of former times. In none was there any real segregation, yet neither in Hemel en Aarde nor in any other of these establishments was there ever any suspicion that other inmates contracted the malady.

All the medical men examined by the Robben Island Commission in 1853 declared their belief that the disease was not contagious.

Dr. Laing: "From most minute inquiries made into the history of many cases. I have come to the conclusion that the disease is not contagious."

Dr. Abercrombie: "I do not regard leprosy as contagious."

Dr. Ebdon: "(4,857). I have formed an opinion as to the nature of leprosy, I have seen a great deal of it—in Western India principally. I do not think it contagious. I do not know what may be the ground of aversion to lepers so commonly entertained here. In India they do not think it infectious or contagious. I do not think that any harm would come from the lepers being allowed to mix with others. The prejudice against lepers is more European than Asiatic, and in Asia the disease is common enough. . . . Lepers are not outcasts from Mohamedan society. . . . I see no moral or medical reason why the lepers and chronic sick should not both be provided for in the same establishment. . . . I would not give way to this prejudice."

Dr. Minto (Medical Superintendent of Robben Island): "I think that the prejudice existing against the leprosy we have here is unjustifiable, because it is not a contagious disease nor the disease which many persons suppose it to be."

Removal of the Asylum to Robben Island.

In 1846 the establishment of Hemel en Aarde was transferred to Robben Island, off Cape Town, where it still is. The following extracts all refer to that place:—

Statistics of Robben Island, 1852.

On December 31, 1852, there were then in what was then known as the "General Infirmary at Robben Island" 202 *males*, of whom 108 were "chronic sick," 34 lepers, and 60 lunatics; and 84 *females*, 33 of whom were chronic sick, 28 lepers, and 23 lunatics. Total, 286.

One of the male lepers pathetically complained—

"The lunatics are a great annoyance to me. If you tell them to go away they will turn upon and abuse you, and you must put up with it. Another will come and demand tobacco, and if he did not get it might take hold of you. Being a weak man, I am compelled to give them what they want."

Robben Island in 1861.

The Rev. Mr. Kuster, a chaplain on Robben Island, in his evidence in 1861, stated:—

“I have learnt on the island that the disease is not contagious, because some chronic sick and lepers have lived a long time together. Dr. Minto, our superintendent, is also of opinion that it is not contagious.” “Lepers, lunatics, and chronic sick have all liberty to move about on the island.” “As a Christian, I do not think it right to banish lepers from their friends and relations as we do at present.”

Dr. Minto, the Superintendent of the Infirmary, said: “(206). I do not think leprosy a contagious disease.”

We now come to a later date. In the year 1892, an Act for the compulsory “segregation” of lepers, was passed by the Cape Parliament, and at once the number imprisoned in Robben Island was greatly increased. To this period the following statistics refer:—

1894.

On May 12, 1894, there were on Robben Island 100 convicts, 280 lunatics, and 555 lepers. In addition to these were 142 children—thirteen in the leper department, but not lepers,—and a number of officers, servants, constables, &c., &c., making up a total population of 1,354.

The lepers admitted into the Robben Island Hospital during the decenniad 1884—1894 were classified as regards race as follows:—

Mixed	...	...	...	...	173
“Kafirs”	...	...	...	...	149
Hottentots	...	...	...	...	139
Whites	...	...	...	...	41
Mozambiques	...	...	...	...	8
Indians	...	...	...	...	3
					513

In 1893 more than one in seven were from the Orange Free State (560 Colonial, 103 Orange Free State). The mortality at that date was very high: “Ninety-one out of 114 who arrived last year died within the year” (1893). Impey, p. 139.

One witness, an assistant medical officer, Dr. Todd, said in his evidence before the Commission:—

“At the present time I think the whole island is practically a graveyard; wherever you walk you find graves. Last year the constant tolling of the bell had such a depressing effect that it had to be stopped. The mortality was very great, and every afternoon nearly the bell was tolling.”

Facts and Statements as to different Races and Districts Affected.

As regards the Hottentots, Mr. G. M. Theal, an agent for Native affairs at the Cape, gave evidence:—

“(338). I know that in the earlier records you do not come across anything concerning leprosy until the middle of the last century, but you do come across observations to the effect that the natives were on the whole a very healthy people.”

“(339. Question): I notice in a report from the Cape Colony to the College of Physicians in 1860, it is stated that the disease was exceedingly common amongst the Hottentots?—(Answer): From my own enquiries, which are only made for historical purposes, I have not traced anything of the kind. I did not go very deeply into the matter, but I came to the conclusion that leprosy was not so prevalent among the Hottentots as it is among the Basutos.

“(340). Do the Basutos include all the Zulus and Kafirs?—The black people, as distinguished from the Hottentots and Bushmen.

“(341). Can you say from any of the records whether leprosy sometimes attacks certain classes in South Africa more than others and is more prevalent in certain localities?—I asked the question about certain localities, and was told that there are localities in South Africa free from leprosy. The Pondos say that leprosy came into their country through people who had moved in from the Colony, and I think very possibly that is true.

“(343). Can any records be obtained with regard to leprosy in Pondoland?—I do not think so. . . . I remember being struck with the observation that the disease had gone into Pondoland because it is sometimes supposed in the Colony to be more common among fishing people than others; but the Kafirs are not a fish-eating people, they will not touch fish at all.” Further on he says: “I have seen a great many lepers in Kafirland, and they all live just the same as others.”

More explicit information is here needed. To what races does the term “Kafirland” apply? Does it include some who are not pure Kafirs? Above all, we want to know—Do the Kafirs, who will not touch fresh fish, object to salted fish as imported from the Cape? Dr. Impey says that leprosy is as yet unknown in Pondoland, and we may safely assume from Mr. Theal’s expressions that, although known, it is rare and of recent introduction. Probably he exaggerates when he says that he has seen many lepers in Kafirland.

Further on in his evidence, Mr. Theal, who had studied the history of Cape Colony and written a valuable book on it, stated

that the first mention of leprosy which he had found was in the middle of the last century, and, asked whether he could assist the Commission in getting further information, replied that he could not, adding :—

“Leprosy in South Africa has only become a prominent subject within the last year or two. The old books of travel would not be likely to give particulars of it, and I do not remember in any Portuguese books that I have studied having seen any mention made of it.”

The Rev. H. C. V. Lembrandt, an authority on Cape history, was asked :—

“What is the earliest record we have of leprosy among the Hottentots ; in the time of Lord Charles Somerset ?—Yes, the preamble of the ordinance speaks of a considerable increase of leprosy of late years within the settlement. That is dated February 11, 1817.”

Mr. Lembrandt subsequently, in explanation of the frequency of leprosy amongst the imported slaves (from Madagascar, Batavia, Coast of Coromandel, &c.), says :—

“Considering the immense number of slaves and the food they lived on, mostly fish and rice, it is not at all improbable that they would have the same diseases here as they would be liable to in their own country.”

Here we have invaluable testimony as to the food which was supplied to their slaves by the Dutch (p. 39).

Dr. Jane Waterston gave some facts on leprosy amongst the Kafirs. She had lived up-country at Lovedale, in the eastern province, and knew that there were lepers who were segregated in their own homes. She was asked as to the existence of a leper village near Lovedale which had been mentioned by Mr. Theal. Her reply was, “It was not a leper village ; it was an isolated hut, and Mr. Theal must have made a mistake. I know the hut well.”

“(4504). Were there many lepers ?—Two or three.”

We have here a noteworthy example of the occasional inaccuracy of the statements of writers, Mr. Theal being a well-credited author.

Dr. Waterston further stated that in her travels in the Zambesi she had not seen any lepers.

Dr. Impey informed the Commission that they had but one white man from the Orange Free State (p. 145).

Dr. Simons, a medical man in Cape Town, formerly practising in Malmesbury, gave evidence as to the races chiefly affected.

“(603). Are they the mixed race or the pure-bred race?—There are no Kafirs in that part of the country.

“(604). How would you class them?—Bastard Hottentots I should say; people from the mission stations, and so on.

“(605). Have you seen any cases in the whites?—Yes, about five or six. I should say that three-fourths occur among the coloured people.”

Asked as to the Malmesbury district, where leprosy had occurred, Dr. Simons stated that the hygienic conditions of the place were excellent.

“(709). Did they use much fish as an article of diet?—The farmers consume dried fish generally for breakfast, but they do not use it in bad condition. Dr. Simons added that in the Malmesbury district the disease was more common on the coast than inland.”

Respecting the Zulu country (*Reserve land*), Mr. Lucas, chairman of the Natal Commission, states :—

“In conclusion, I may say that I wrote to Mr. Osborne, resident in the Reserve Zululand; he kindly made enquiries, but could not learn that leprosy was known or had ever been heard of in the Zulu country.”

Evidence as to the Value of Segregation.

Dr. Simons, who was examined before a select committee in 1889 and again before the Commission in February, 1894, said, on the latter occasion, that he had quite changed his opinion as to the advisability of compulsory segregation; asked—

“(884). For what reason?” he replied: “I have since got more information about the matter from various papers. In Norway, for instance, they treat the disease successfully; it is a fact that it is decreasing to a large extent, and there is no compulsory segregation; but, of course, isolation of the affected, showing that those very drastic measures are not required. I did not know this at that time.

“(885). Complete segregation is a mere name, is it not? You have not complete segregation at Robben Island?—No.”

It will be seen that Dr. Simons was still in favour of securing isolation of lepers as far as practicable, but was willing that it should be in their own homes.

Mrs. Laubser, a paying patient who had been four months on the island, stated that she had come there voluntarily—

“Thinking the doctor would make me all right. I was afraid my husband and children would catch the disease, so I consented to be separated from them all.

“(3,400). Have you any children with you?—Yes, two; I have seven others at home. I have the two youngest with me. My husband is alive. My youngest child is not a year old. I have a dining room and two other rooms.”

Thus it will be seen that two children were allowed to run the supposed risk of contagion, whilst, in order to attain so-called "isolation," seven others were deprived of their mother's care.

(1,550). Dr. Impey, the medical superintendent, said, respecting the children in the establishment :—

"I am not in favour of keeping children on the island at all. *So far as leprosy is concerned they are quite safe*, but no one will take charge of them ; that is the point." (Vol. i., page 103.)

The Matron of the establishment deposed, in answer to questions, that she had eleven healthy children in her department. The eldest was 7 years and the youngest 6 months. "Are these children separated from their mothers?"—"No, they do not want to be separated." "Do these children mix pretty freely with all the leper patients?"—"Yes, and eat at the same table."

Is it possible to think, after such an admission, that the officials of Robben Island really believe that leprosy is contagious, or that segregation is important?

Statements as to Contagion and Mode of Spreading, &c.

The evidence of Dr. Kohler, the medical inspector appointed by the Orange Free State to visit Robben Island, was remarkably clear and instructive (p. 299). Asked whether he considered leprosy contagious, his reply was, "No ; you cannot explain how it is spread." "Do you consider it a source of public danger?" "No ; because there is no proof that it is transferred from one person to another." Further on in his evidence (2,190), he says : "Contagious diseases spread as a rule, whereas leprosy as a rule does not spread. In innumerable cases only one member of a family has it." Pressed as to whether the occurrence of several leper cases in the same family did not imply contagion, he answered : "If you find several lepers in one family you might think that one got the disease from the other. But if you investigate deeper and find that in innumerable cases only one member of a family is affected, you are forced to the conclusion that the former are not due to contagion, but to infection from a common source." Asked, "If you were working with lepers on Robben Island, would you take any precautions against them?" Dr. Kohler replied, "No," and added that he

would wash his hands for the sake of cleanliness. Asked further, "You would not have any fear of getting leprosy?" "No."

Dr. Kohler's evidence extends over many pages of the Report, and is well worthy of perusal. He avows that he can give no explanation whatever as to the way in which leprosy spreads, but is clear that it is not by contagion. Had he adopted the food (*i.e.*, fish), hypothesis, his difficulties would have vanished, for all the facts and arguments which he adduces are consistent with that.

Dr. H. Ross, formerly surgeon-superintendent of the island, in reply to the question—

"Do you not consider it contagious?" said: "(2,393). I do not think it contagious in the ordinary sense of the word.

"(2404). Is it inoculable?—For six years I have never known any case communicated, although the patients are constantly mixed up with everybody in the island who has liberty. I have never tried inoculation."

Dr. Ross also, when asked as to the cause of its prevalence, said:—

"I cannot understand why it is spread so widely about the world; it seems to puzzle everybody." (Vol. i., page 152.) "In crowded places where the type of life is low and food scarce you see a good deal of it spreading, as in China and India."

Dr. Ross was further asked:—

"(2,501). Is it caused in any way by eating any specific articles of diet, such as fish, diseased grain, and so forth?—The lepers themselves used to say that they always got worse when they ate fish. . . .

"(2,502). Do you know from your own experience that the patients get any exacerbation when on a fish diet?—Yes, I have seen that.

"(2,503). Do they attribute it to the fish?—I think it is due to the salt in the fish. I have seen fresh eruptions come on after a couple of days of feverishness.

"(2,520). Are you speaking of salt fish?—Yes.

"(2,521). You do not mean to infer, do you, that a diet of salt fish could cause leprosy?—No, but it is unsuitable for the patients."

Dr. Dixon, who had resided some years on the island, was asked:—

"(2,694). What are the reasons for your doubting the communicability of the disease through contagion—direct contact?—My grounds are chiefly negative. I have collected a number of instances where there is a striking absence of any history of direct contagion."

Dr. Todd, asked how the disease spread, replied:—"I am unable to form any idea how it is spread."

After stating that he had seen leprosy in other parts of the

world, he was asked whether he had formed any conclusion as to its contagiousness, he replied "No."

Dr. Impey, the medical officer of the establishment, was asked :—

"Is it not the fact that a very large number of healthy persons at different periods have been brought into contact with lepers on Robben Island, both by eating, sleeping, sexual contact, and so on?—Yes; not very many, perhaps.

"(1153). Have you records of any cases where leprosy has spread from diseased persons to healthy persons on Robben Island?—No; none.

"Then notwithstanding the intimate contact of healthy persons with lepers on Robben Island there is not a solitary case in your recollection or in the records of the island, I understand, which would enable you to state the disease passed from diseased to healthy persons?—Quite so.

"You do not desire to qualify that in any way?—Not at all."

Asked as to whether the disease was confined to the poor, Dr. Impey said: "There are some very rich patients on the island, although the majority belong to the poorer class."

Further on (1599) Dr. Impey stated :—

"There is a man on Robben Island now who is worth £10,000. He has been diseased a long time. He has a beautiful farm, and could be thoroughly trusted to live on his farm. We removed him from his farm and put him into the asylum."

Dr. Landsberg, of Cape Town, deposed that the disease affected persons of all occupations and of all colours.

A Cured Patient still there.

Dr. Eyer deposed to the case of a man who had been one of the first patients on Robben Island, and was still there, although he had had no manifestations of leprosy symptoms for thirty years.

(To be continued).

THE "PRACTITIONER" for May.

The greater part of the May number of the *Practitioner* is occupied by a series of papers on "Rheumatoid Arthritis."

This plan of bringing together in one issue the experiences of many men having special opportunities for observing and managing cases of a particular disease has many and obvious advantages

From lack of time it too often happens that the busy practitioner is unable to search out from the bewildering mass of medical literature the salient points of recent investigation and modern treatment which he wishes to know about, and such a difficulty—and it is a very frequent one—will be greatly minimised, if not wholly overcome, by this provision of collective information.

The disease which is brought under review is presented in a compact form, so that all recent facts concerning it are marshalled within readable compass, and it is treated by the various contributors from different points of view in such a manner that the features of the disease-picture, when completed, have some chance of being seen in proper perspective. Every man sees his case and writes about it “through his own spectacles,” but when a disease can be viewed by the general reader through the spectacles of many experts, the risk is obviated of attaching undue importance to the views of any one writer. Other diseases, cancer, pneumonia, &c., have been similarly dealt with on previous occasions by the *Practitioner* and this “Rheumatoid Arthritis” number is no less valuable than its predecessors. It does not lead us much further on the road of accurate and successful therapeutic management, but one or other of the various suggestions and theories which are put forth may turn out to be the finger-post on the highway of cure for this most untractable disorder.

A summary at the end of each such number giving the broad outlines of the various communications, would be a valuable epitome which would add to the usefulness of this new and important method of medical journalism.

COLLEGE NOTES.

BY THE DEAN.

THE Summer Term of Practical Classes commenced on May 14. The entries are on the whole an improvement on previous terms, but the numbers are still kept in check by the continuance of the war. With a return of peace, which we have some reason to hope is now within measurable distance, many of our members, together with a large number of other medical men, will return from Africa,

and will be free to avail themselves of the opportunities for "rubbing up" which we are now able to offer in all departments of practical and scientific work. The syllabus is the same as before, but has added to it a systematic course of lectures on "Diseases of Children" which is being conducted by Dr. Still.

* * *

CLINICAL lectures will be delivered during this month, on the 6th, by Mr. William Rose, on "The importance of Early Diagnosis and Operation in Surgical Diseases of the Abdomen;" and on the 20th, by Dr. Ferrier, on "Jacksonian Epilepsy."

* * *

MR. JAMES BERRY gave an excellent lecture on the 28th ult. on "The Operative Treatment of Adenomata." Mr. Berry has done a large amount of excellent and successful work in the surgical treatment of gland lesions, and one lecture so inadequately told the whole of his story that we hope to induce him to give us a second instalment of his experiences in one or two further lectures during the Autumn Session. This lecture was the first belonging to the series of "Courses of Special Lectures" to which reference has already been made in these columns. Other two courses are arranged for July: one consisting of two lectures to be delivered by Dr. Hillier on the 9th and 23rd on "The Modern Treatment of Tuberculosis;" and the other of three lectures to be given by Dr. Bowles, on the 6th, 13th and 20th, on "Some Practical Points in the Treatment of Threatened Asphyxia."

These courses of lectures are arranged for 5 p.m. so as to suit the majority of men, and on days when no other work is going on in the College. They are free to members, and it is hoped that the lecturers will be rewarded for their trouble by having satisfactory audiences.

* * *

WE are pleased to be able to announce that Sir John Batty Tuke, M.D., the new Member of Parliament for the Universities of Edinburgh and St. Andrews, has become one of our Vice-Presidents. Sir John is a well-known and leading authority on mental disease. In Parliament his practical experience will be of the highest value upon all medical questions, and especially upon such as deal with

lunacy. He has promised us a clinical lecture during autumn to which we look forward with pleasurable anticipation.

* * *

MANY will remember the excellent course of lectures delivered last spring by Dr. Ernest Maddox, of Bournemouth, on "The Ocular Muscles." He has consented to repeat his course during this month, and has arranged to give five lectures on consecutive days, from the 25th to the 29th inclusively. The fee is one guinea, and entries may now be made with Captain Pinch.

* * *

DR. MILLER ORD's indisposition still continues and has compelled him not only to seek a prolonged rest in the country but also to shake himself free from many of his appointments, among them, unfortunately for us, the Chairmanship of our Council. His loss will be much felt and his shoes will be difficult to fill. He possesses in quite an unusual degree the combination of *fortiter* with *suaviter* which ensures the successful piloting of any Committee or Council, and his accurate knowledge of procedure and capacity for business has stood the Council in good stead on many difficult occasions.

Dr. Ord still retains his seat on the Council, and every member of the Polyclinic will earnestly hope that his health may soon be restored sufficiently to enable him to resume an active part not only in the Council Chamber but also in the Consultation Rooms.

* * *

DURING April the routine of the College was interrupted by the Easter Vacation.

On account of illness, Sir William Broadbent and Mr. Johnson Smith were prevented conducting the work of the Consultation Rooms on the 24th and 18th of the month.

Only sixteen Consultations were held, but these were attended by the usual average of members and by an adequate number of patients.

The attention of members is again called to the question of "Material." Every interesting case will be welcomed, but when possible, previous notification is desirable in order that the most may be made of the opportunities afforded us. Seventeen cases on

one afternoon, as happened one day recently, is a trial for any one man, however enthusiastic.

Three cases only, on the other hand—as happened on another recent afternoon—are too few to afford sufficient variety. It is very desirable, from every point of view, to equalise the available supply.

Arrangements are in progress for holding a *Conversazione* in the College on the evening of Wednesday, July 4, for the special purpose of inaugurating the new Museum. An oration will be delivered on the occasion, by Professor Osler of Baltimore.

* * *

THE clinical lectures given by Dr. Dreschfeld of Manchester, and by Colonel Kenneth McLeod of Netley Medical School were well up to the average of those which preceded them.

Dr. Dreschfeld, in an extemporaneous discourse that bristled with instructive facts from beginning to end, gave a clear and concise account of the state of our present knowledge in regard to Cirrhosis of the Liver. Some of his views were novel and seemed to throw a fresh light upon a few of the problems connected with cirrhosis which have heretofore proved to many minds a stumbling block in the way of a clear conception of the varieties of this pathological condition. The lecture was illustrated by many useful diagrams and also by a series of microscopic and wet specimens.

To any one wishing to dip further into this subject a perusal of Dr. Cheadle's Lumleian lectures is to be recommended. Read side by side with Dr. Dreschfeld's exposition, the whole story is complete and up to date.

Colonel Kenneth McLeod's lecture on "Elephantiasis" was equally interesting and attractive. He dealt with his subject in minute detail and traced this curious disease through all its various phases, dealing with it from the etiological, pathological, and symptomatological standpoints, and finally indicating the points to be considered in relation to diagnosis and prognosis and the various means to be adopted for suitable treatment. The diagrams and sketches illustrative of Colonel McLeod's lecture added much to the interest of his remarks; and special point was given to the pathological aspect of the discourse by the exhibition of two living

specimens of the *filaria nocturna* for which the lecturer was indebted to the kindness of Mr. D. C. Rees of the London Tropical School.

The Chair was occupied by Sir Joseph Fayrer and one of Colonel McLeod's most striking illustrations of the extent to which an elephantoid mass may attain was afforded by a reminiscence he related of having once watched Sir Joseph "remove a man from a tumour," that is to say a growth was separated which actually weighed more than the man from whose tissues it had grown.

It has been decided to close the College from July 27 till September 3.

This concession of a vacation is granted for this year only, as it is felt by many members of Council that in future years, when our requirements demand a larger staff, it may be possible, and also desirable, to carry on at least the greater portion of the work without break from year's end to year's end.

Many graduates come to London, both from the provinces and from abroad, during August to whom the facilities of the Polyclinic would be a boon. This is fully recognised and will be provided for when we are in possession of greater resources, but this year it seemed wise to sanction such an interregnum in the work as would afford all the officials opportunity for a short respite from duty.

* * *

The annual dinner of the College took place at the Trocadero Restaurant on the evening of Thursday, the 31st ult. Lord Strathcona and Mount Royal occupied the chair and was supported by many influential men, whose interest in the work of the Polyclinic both brought them to the dinner and prompted them to cheer the Treasurer's drooping spirits by substantially increasing his balance at the bank.

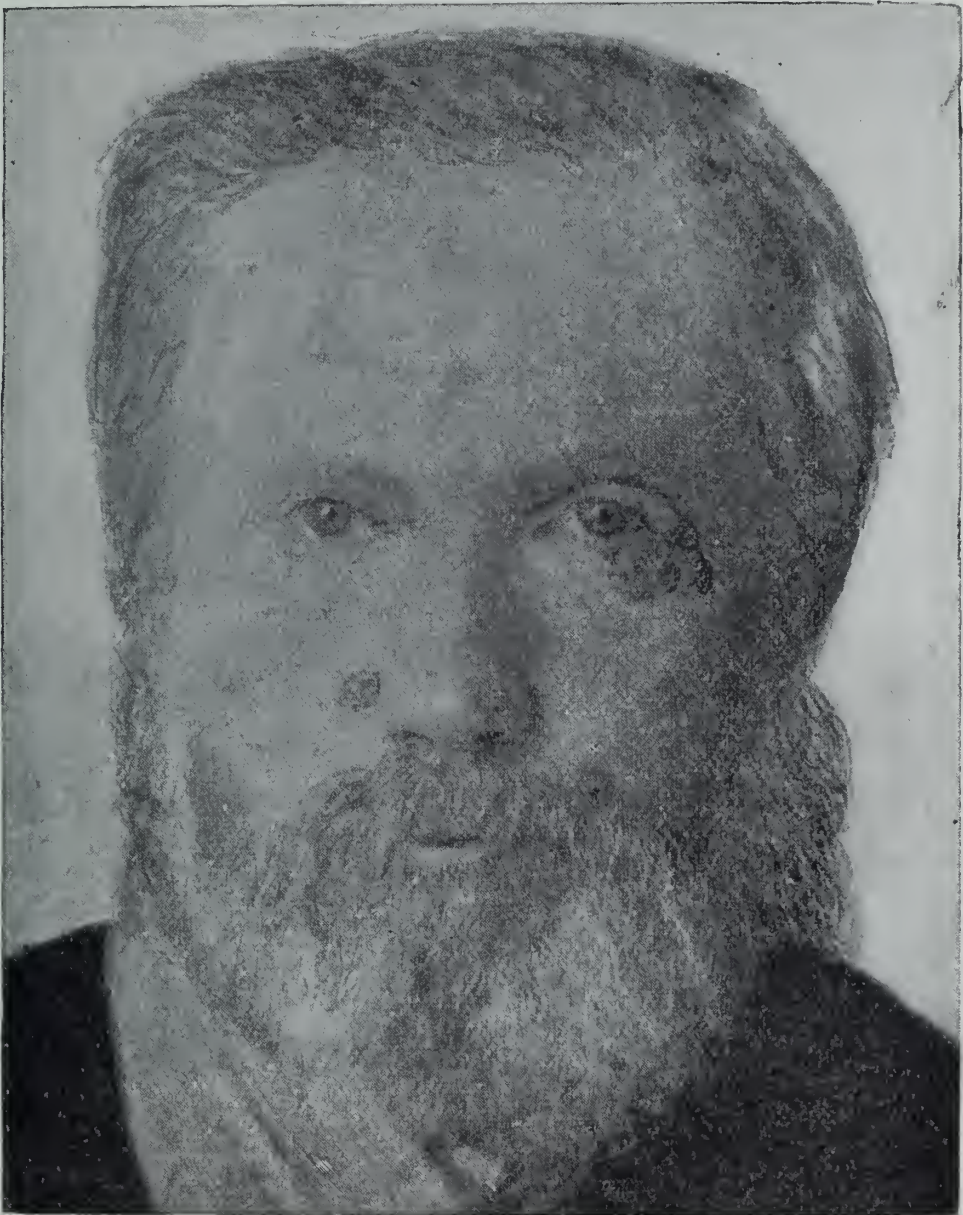
On the preceding Saturday—the 26th—an afternoon Conversation was held at Chenies Street, and was attended by a large company of ladies and gentlemen, who were thus afforded an opportunity of seeing the College and of visiting the new museum building.

Both these events occurred so near the date of our present issue that further details concerning them must be reserved for the July number.

MUSEUM NOTES.

Portraits illustrating Granuloma Fungoides.

AMONGST these we have four portraits showing different regions from the case of a man who was sent to the Clinic at Park Crescent, by Dr. Stocker of Forest Gate, and who died a few months later. The following are some of the facts as to his history.



C., aged 58, attended in March, 1899. An eruption began on the arms as a sort of nettle rash five years ago, and spread to the thighs. The "lumps" had been coming for about a year. There were large bossy masses on the back of neck (*see other portrait*)

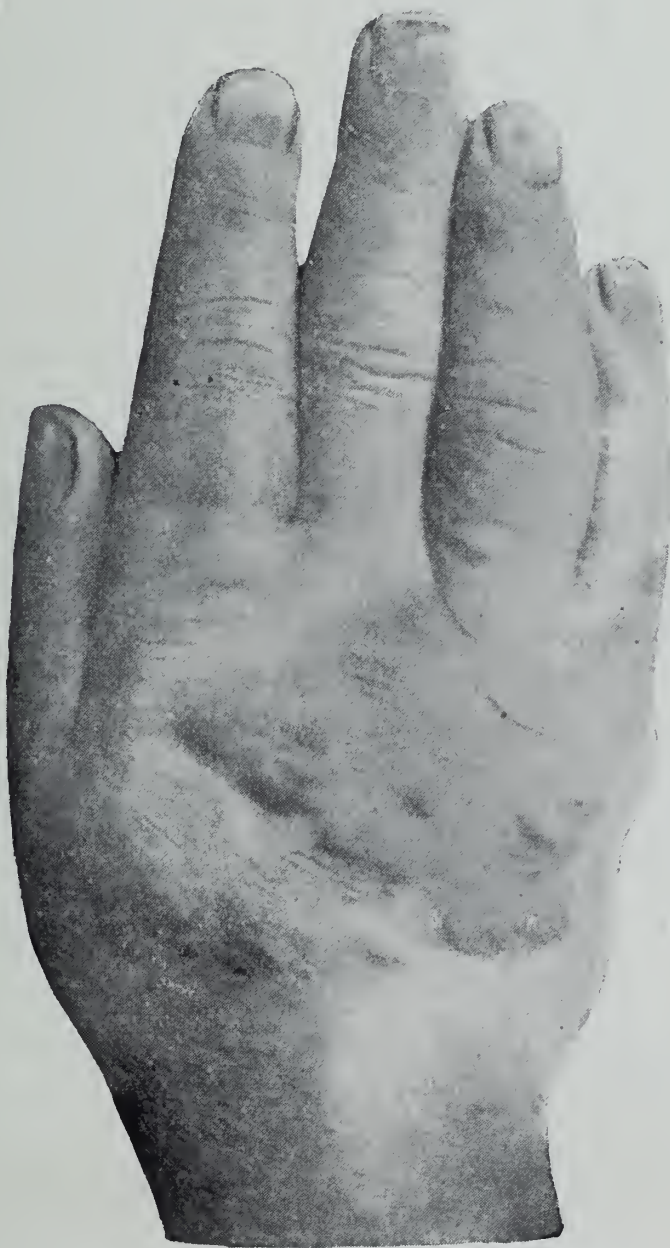
adherent deeply to the skin. There was a general dusky eruption of ill-margined patches which almost covered the body. Some of them were like wheals and others lichenoid. On the face were some small growths. Gland-masses were to be felt deep in the neck but none in the armpits.



Blue patches on the hands of an Adult Man.

A coloured sketch of hand given to Mr. Hutchinson by Dr. Cæsar Boeck of Christiania. It was taken in 1867, and the case is described in the *Norsk Magazin for Lagerid*, 1867, p. 339, by Dr. Wilhelm Boeck. It was named "Sarcoma angiomatosum (Kaposi's

so-called multiple, pigment-sarcoma"). The growth was "examined microscopically and found to be a sarcoma." The patches were of a deep blue colour. The patient was a sailor. He continued his vocation and the sequel was not known. The blue patches represented are in the coloured portrait exactly like those shown in one



published by Mr. Hutchinson in his Atlas of Illustrations. They are also like those given in Hebra's Atlas as "Sarcoma melanodes." The true nature of the malady is somewhat doubtful. It appears to be in some connection with gout. The patches are symmetrical and very slow in progress.

CORRESPONDENCE AND ANSWERS.

“DEAR SIR,—

“With reference to your remarks on ‘Tuberculosis and Leprosy’ (THE POLYCLINIC, No. 5, May, 1900, p. 273, &c.), I take the liberty of pointing out that the bacillus lepræ has been found in the tissues of the skin in ‘macular erythematous or anæsthetic’ form of leprosy by Darier (Berlin Lep. Congress) and others. As to contagiousness of leprosy, Dr. Prince Morrow, in the latest monograph on Leprosy (*Twentieth Cent. Pract. of Med.*, vol. xviii., 1899), refers to the point, and does not agree with Hirsch (? 1885) (mentioned by you in THE POLYCLINIC, No. 4, 1900, p. 271).

“Believe me,

“Yours very faithfully,

“GEORGE PERNET.”

* * *

MEDICUS.—Caries of the teeth, although it has been proved to have occurred in prehistoric times in the teeth of man is, we believe, unknown in those of any other animal. A good work on malformations and diseases of the teeth in relation to medicine is a desideratum. We do not know of any such work. You will find perhaps more information on the subject in Tomes’ Dental Anatomy than in any other work.

* * *

TERATOLOGIST.—There is a good paper on “Congenital Hypertrophies, Local Giantism, and Unilateral Giantism,” by Mr. W. Anderson, in the *St. Thomas’s Hospital Reports*, vol. xi., 170. He draws attention to their frequent association with nævus and other vascular tumors.

* * *

SENEX sends us a soliloquy of the dyspeptic: “Nec tea cum possum vivere nec sine tea.” It is taken from “The Miseries of Human Life.”

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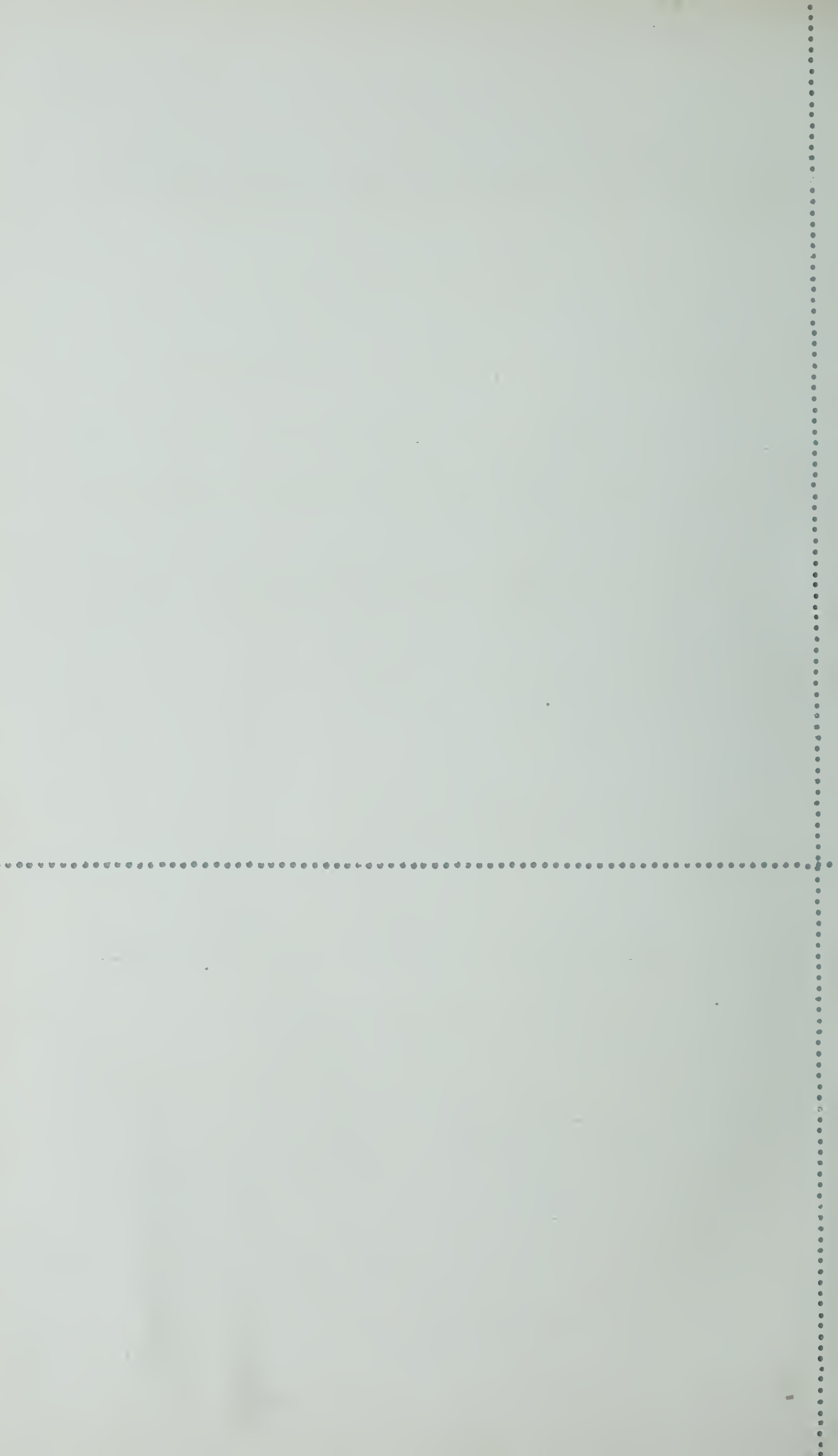
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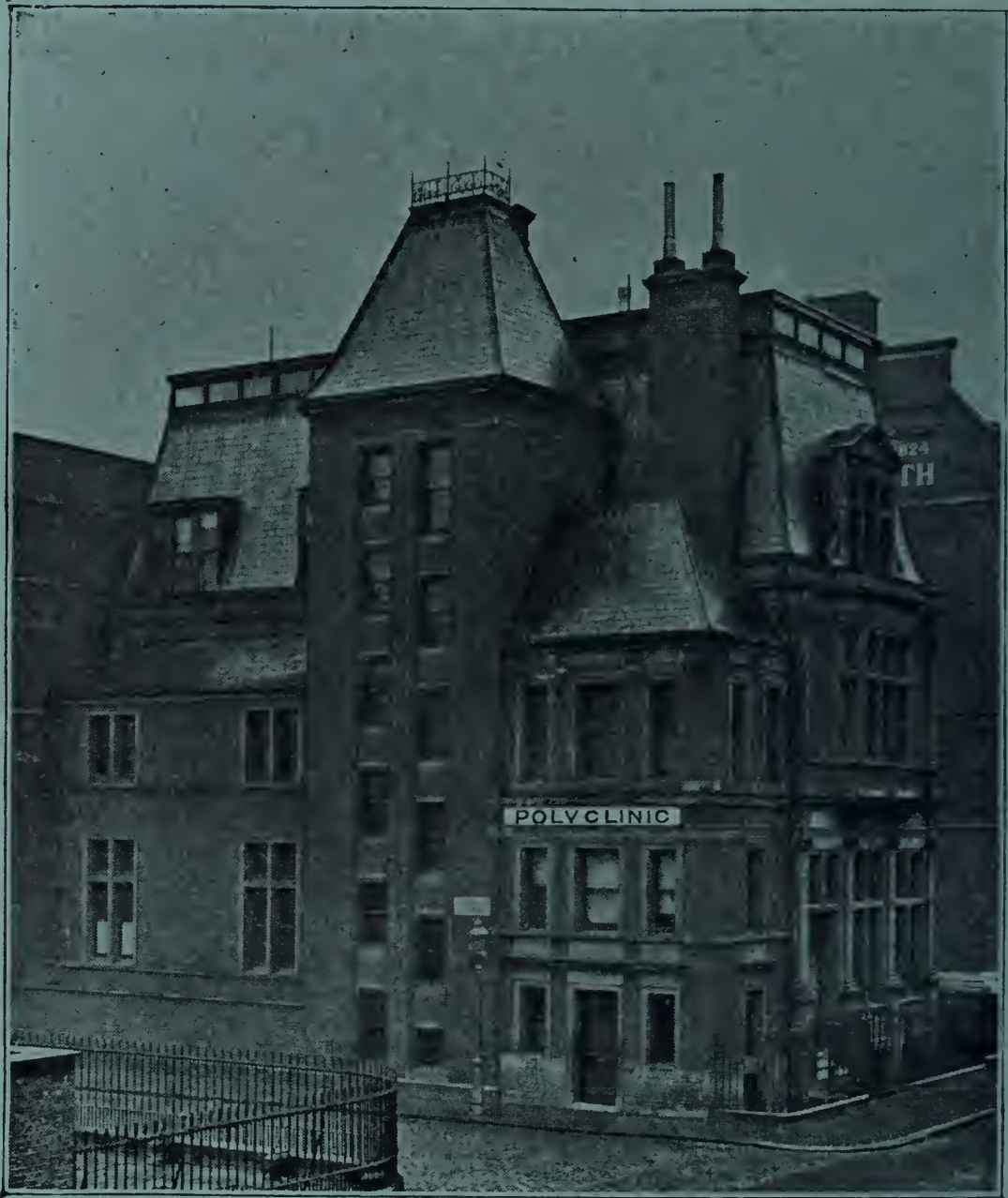
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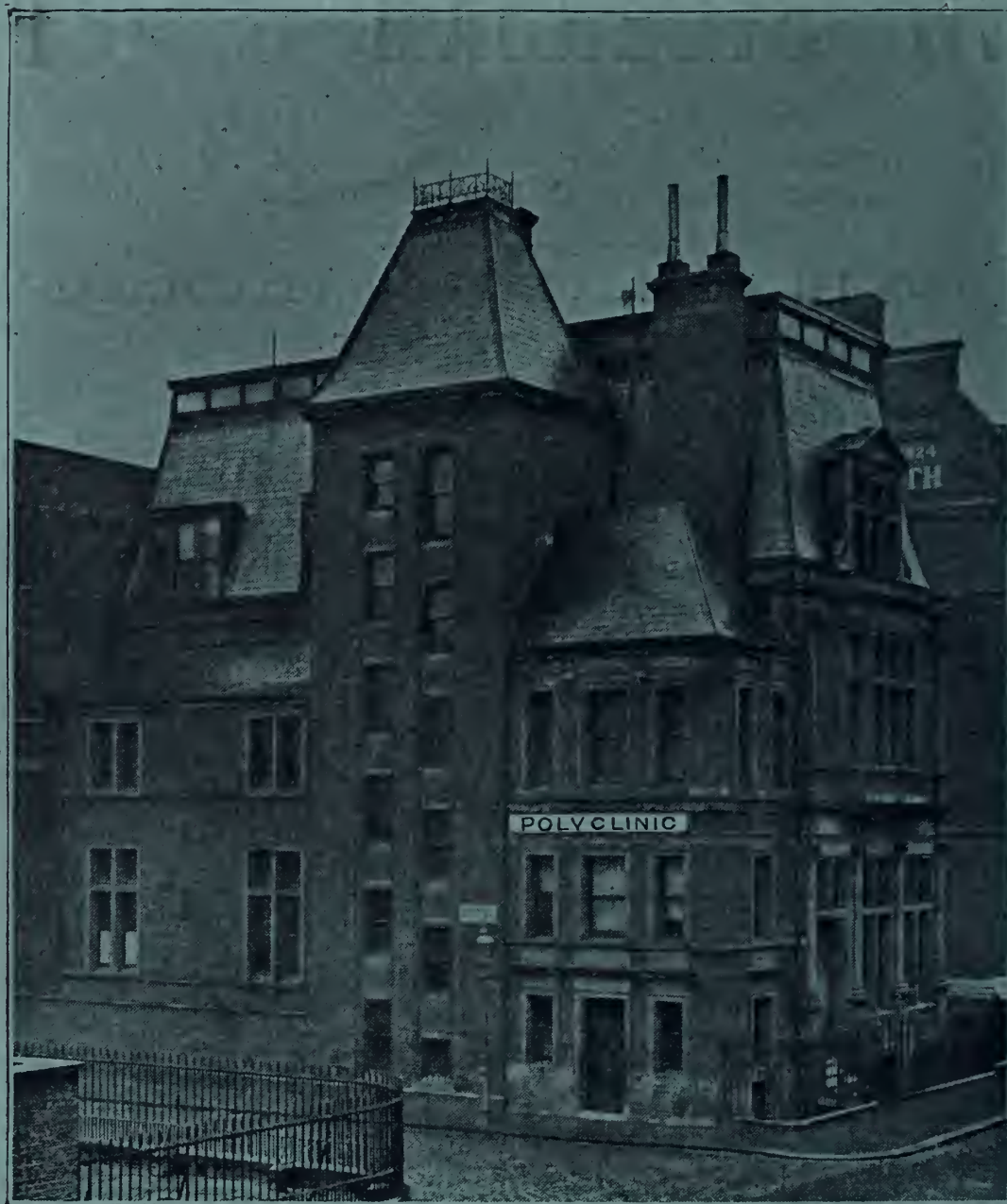
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President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

WINTER SESSION, 1900.

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis	{	Seymour Taylor, M.D., M.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S.
Clinical Examination of the Nervous System	{	James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.
Practical Ophthalmology : the use of the Ophthalmoscope and Refraction	{	E. Treacher Collins, F.R.C.S. W. Holmes Spicer, M.B., F.R.C.S. John Griffith, F.R.C.S.
Practical Otology	{	Arthur H. Cheatele, F.R.C.S. Richd. Lake, F.R.C.S. J. Dundas Grant, M.D., F.R.C.S.
Practical Rhinology and Laryngology	{	StClair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P.
The Application of the Röntgen Rays		F. Harrison Low, M.B.
Clinical Microscopy		A. E. Hayward Pinch, F.R.C.S.

COURSES OF LECTURES.

General Ophthalmology... ..	R. Marcus Gunn, M.B., F.R.C.S.
Insanity : its Medical and Legal Treatment	G. H. Savage, M.D., F.R.C.P.
Lectures and Demonstrations on Diseases of the Skin	Phineas S. Abraham, M.D., F.R.C.S.
Comparative Pathology	Woods Hutchinson, A.M., M.D.
Administration of Anæsthetics ...	J. F. W. Silk, M.D.

CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology	Professor Crookshank, M.B.
Mental Diseases... ..	Maurice Craig, M.D., M.R.C.P.
Hygiene and Public Health ...	A. Wynter Blyth, M.R.C.S., F.C.S.

LENT TERM, 1900.

Commences Monday, March 5th ; ends Thursday, April 12th.

CLINICAL CONSULTATIONS AT 4 P.M.

Mondays (Skin) ; Tuesdays (Medical) ; Wednesdays (Various) ;
Thursdays (Surgical) ; Fridays (Eye, Ear, Throat, and Nose).

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis. Tuesdays and Thursdays, at 6 P.M. Commences Tuesday, March 6th. Fee, £2 2s. Dr. Seymour Taylor and Mr. James Cantlie.

Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M. Commences Friday, March 9th. Fee, £2 2s. Dr. Harry Campbell.

Practical Application of Röntgen Rays. Thursdays, 3 P.M. Commences Thursday, March 8th. Fee, £2 2s. Dr. Harrison Low.

Practical Ophthalmology : the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M. Commences Friday, March 9th. Fee, £2 2s. Mr. John Griffith.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commences Wednesday, March 7th. Fee, £2 2s. Dr. StClair Thomson.

Practical Otology. Mondays, 5 to 7 P.M. Commences Monday, March 5th. Fee, £2 2s. Dr. Dundas Grant.

Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30 P.M. Commences Monday, March 5th. Fee, £2 2s. Mr. Hayward Pinch.

LECTURES.

(Conditional upon a minimum number of entries being received.)

Diseases of the Eye. Mr. Marcus Gunn.

Diseases of the Skin. Dr. Phineas Abraham.

Comparative Pathology. Dr. Woods Hutchinson.

Insanity : its Medical and Legal Treatment. Dr. Savage.

Administration of Anæsthetics. Dr. Silk.

Fee for any one course of Six Lectures, £1 1s.

LABORATORY AND CLINICAL CLASSES.

Practical Bacteriology. Daily, 10 A.M. to 1 P.M., and 2 to 5 P.M. Fee, £5 5s. Professor Crookshank.

Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee, £2 2s. Professor Crookshank.

Hygiene and Public Health. Fee, £2 2s. Mr. Wynter Blyth.

Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.

Morbid Conditions of the Urine and their Clinical Significance. Fee, £2 2s.

SYLLABUS OF TEACHING.*

Clinical Lectures will be given on alternate Wednesdays at 5 p.m., commencing March 14th.

CLINICAL CONSULTATIONS.

These will take place in the afternoon, between the hours of 4 and 6. Particulars will be announced at the Polyclinic, in the Journal, and in the weekly Medical Press. In connection with these Consultations, Clinical Assistants will be appointed. For the present, Consultations will be held every Monday, Tuesday, Wednesday, Thursday, and Friday.

PRACTICAL CLASSES.

Entries for the following Practical Classes may now be made. *Each course will extend over six weeks*, and will be conducted so as to afford practical instruction to each member of the class. Patients illustrating the various diseased conditions will be submitted for examination. The number of students permitted in each class will be limited, but, if required, supplementary classes will be provided :—

MEDICAL AND SURGICAL ANATOMY AND PHYSICAL DIAGNOSIS.

Tuesdays and Thursdays, 6 to 7 P.M., commencing March 6th.

*Fee :—*Two guineas.

This course will be illustrated on the living subject, and by specimens, diagrams, and models. It will include—

1. Practical instruction in the normal positions of the several organs and their various parts, and the relationship of surface anatomy to the subjacent viscera.
2. The principles and methods of case-taking.
3. The application of inspection, palpation, mensuration, percussion, and auscultation in the clinical study of the thoracic and abdominal viscera.

* All communications regarding the classes should be addressed to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

4. The use of medical instruments and apparatus, with demonstrations of methods and results. In this section will be studied the Cardiograph, Sphygmograph, Pneumograph, and records obtained by their aid; the Clinical Thermometer and Temperature Charts; the Hypodermic Syringe and its use; the Stomach Pump and Stomach Syphon; Southey's Tubes and various Aspirators; Inhalers and Intra-Laryngeal Medication; Enemata, their preparation and use; Venesection, Transfusion, &c., &c.

5. BONES.—Mechanism; structure as bearing on fractures.

6. JOINTS.—Anatomy; dislocations and principles of reduction.

7. MUSCLES.—Grouping of muscles according to action and nervous supply; tendons, their sheaths and division points; club foot.

8. ARTERIES.—Anatomy of main arteries; points at which pressure is most readily applied; sites for ligature; collateral circulation; tourniquets.

9. VEINS.—Anatomy; venesection; varicose veins.

10. LYMPHATIC SYSTEM.—Grouping of glands; distribution of lymphatics.

11. NERVOUS SYSTEM.—Brain, and the localisation of cranial lesions; the convolutions, centres, origins of cranial nerves, vascular supply, relations to surface of skull; trephining. Cranial nerves, anatomy, diagnosis of lesions affecting. Spinal nerves, their area of supply; localisation of spinal lesions; laminectomy; operations for spina bifida.

12. REGIONS.—Cranium; orbital, nasal, oral, and aural regions and cavities. Limbs, the surgical anatomy of. Fractures, their anatomy, and principles of treatment. The surgical anatomy of hernia and the genito-urinary organs.

Bandaging. Application of splints. Surgical instruments.

THE METHODS OF INVESTIGATING CASES OF DISEASE OF THE NERVOUS SYSTEM.

Fridays, 2 to 3.30 P.M., commencing March 9th.

Fee:—Two guineas.

The anatomy and physiology of the nervous system.

Brain and spinal cord topography.

Functions of the brain and spinal cord.

Family history in nervous disease.

Personal history and habits in nervous disease.

Condition of the patient at the time of examination.

General Appearances.—Unsteadiness, tremor, deformities, pallor, nervousness, &c.

Gait—Spastic, ataxic, hemiplegic, functional disturbances.

Spontaneous movements.—Choreiform ; athetoid ; tremor.

Speech defects—Articulatory ; aphasic.

Motor Symptoms.—Paraplegia ; monoplegia ; hemiplegia ; cranial nerve paralyses ; isolated paralysis of spinal segments ; isolated paralysis of spinal nerves ; general neuritis ; electrical testing.

Sensory Symptoms.—Spontaneous sensations ; impaired sensibility, common, for pain, for heat and cold ; perverted sensibility, allocheiria, &c.

Special Senses.—Smell ; taste ; vision ; ophthalmoscopic appearances ; hearing.

Trophic symptoms.

Cases illustrating different types of nervous disease.

THE USE OF THE RÖNTGEN RAYS IN MEDICINE AND SURGERY.

Thursdays, at 3 P.M., commencing March 8th.

This subject will be taught in the laboratory, which has recently been equipped with the most modern apparatus. Instruction will be given in short courses of practical work under the supervision of Dr. Harrison Low, and each member of the class will have the opportunity of practising the necessary methods and processes. It is proposed that the laboratory shall be open for teaching on Thursdays at 3 P.M., but in respect to days and hours, an endeavour will be made to meet the convenience of practitioners wishing to study this subject. Fee for four practical lessons :—Two guineas.

PRACTICAL OPHTHALMOLOGY : THE USE OF THE OPHTHALMOSCOPE AND REFRACTION.

Fridays, 5 to 7 P.M., commencing March 9th.

Fee :—Two guineas.

- I. Optical principles and subjective testing.
- II. The ophthalmoscope, and how to use it.

- III. Retinoscopy.
- IV. Abnormalities of refraction and the prescribing of glasses.
- V. Ocular movements: their anomalies and derangements.
- VI. The field of vision.

PRACTICAL RHINOLOGY AND LARYNGOLOGY.

Wednesdays, 5 to 7 P.M., commencing March 7th.

Fee:—Two guineas.

Members of the class are requested to provide their own laryngoscopes and the ordinary instruments required for clinical examination. (A list of these will be provided by the teacher.) The class is held in the dark room, and for each member there is a separate table and laryngoscope lamp.

The practical examination of the upper air passages will be demonstrated on patients, and the course will be illustrated by instruments, models, drawings, diagrams, and specimens.

March 7.—Methods of illumination; position; necessary instruments; the external nose.

„ 14.—The examination of the nasal fossæ; specula; probes; cocaine; the medication of the nasal cavity, composition of nasal lotions, &c.; affections of the septum.

„ 21.—The accessory sinuses of the nose, their situations, openings, relations, and the methods of their exploration; transillumination; the physiology of smell and of nasal respiration.

„ 28.—The naso-pharynx and pharynx; the tonsils.

April 4.—The larynx.

„ 11.—The trachea and œsophagus; tracheotomy; intubation; dysphagia.

PRACTICAL OTOLOGY.

Mondays, 5 to 7 P.M., commencing March 5th.

Fee:—Two guineas.

- I. Inspection of auricle, meatus and membrane, specula, &c.; air and bone conduction; tests for hearing; rules for using the tuning-fork, Rinne's test, &c. (Cases.)

- II. Diagnosis of obstructive and nerve deafness in general ; cerumen ; indrawn membrane, dry perforations, cicatrices, &c. ; Siegel's speculum, "artificial drum," &c. Syringing. (Cases.)
- III. Varieties of obstructive deafness ; examination of the Eustachian tubes, rhinoscopy, inflation, auscultation, Politzer's bag, Eustachian catheter, &c. (Cases.)
- IV. Discharges from the ear, cleansing, instillation of drops, cauterisation, &c. ; mastoid disease, &c., polypi, granulations, "attic disease." (Cases.)
- V. Varieties of nerve-deafness, labyrinthine, central, functional, &c. ; use of Galton's whistle, &c. ; investigation of auditory and neighbouring nerves, &c. (Cases.)
- VI. Varieties of tinnitus aurium ; compression of vertebral arteries ; application of galvanism. (Miscellaneous cases.)

On each occasion the members of the class will receive a typed *résumé* of the matter dealt with. The most of the time will be occupied in the actual examination of cases.

CLINICAL MICROSCOPY.

Mondays and Wednesdays, 2 to 3.30 P.M., commencing March 5th.

Fee :—Two guineas.

Syllabus.

The Microscope. Lenses and Objectives. Spherical and chromatic aberration. Abbé condenser. Conditions of visibility of microscopic objects seen by transmitted light. Refraction images, colour images.

The objects and chemical principles of staining.

The preparation of blood films. Diapedesis and phagocytosis.

Sterilization. Culture media and their preparation. Drop, Test-tube, Stab, Stroke, and Plate cultivations.

Bacteria, their structure and chemical composition. Morphological classification, method of growth and reproduction, products of growth. Classification of bacterial diseases.

Immunity, autogenous and heterogenous. Mithridatism. Toxines and antitoxines. Variolization and vaccination, preventive serums.

Septicæmic Processes—Anthrax, Syphilis, Typhoid.

Local Inflammatory Processes—Staphylococcus and Streptococcus. Pyogenes aureus, Frankel's pneumococcus, gonococcus, glanders, tuberculosis.

Intoxication Processes. Tetanus. Diphtheria.

Rabies. Pasteurism.

The preparation of microscopic sections.

Fresh specimens. Hardened specimens. Methods of hardening, embedding, cutting and mounting sections. Microtomes.

Inflammations. Infiltrations, Degenerations, Amyloid Disease.

Tumours—

(a) Connective tissue. Innocent and malignant.

(b) Epithelial tissue. Innocent and malignant.

(c) Cysts.

MORBID CONDITIONS OF THE URINE AND THEIR CLINICAL SIGNIFICANCE.

Fee :—Two guineas.

Particulars on application.

COURSES OF LECTURES.

General Ophthalmology.

By R. MARCUS GUNN, F.R.C.S.,

Surgeon to the Royal Ophthalmic Hospital, Moorfields, &c.

Fridays, at 3 P.M., commencing March 9th.

Fee :—One guinea.

LECTURE 1.—On the external examination of the eye.

LECTURE 2.—Visual tests.

LECTURE 3.—Syphilitic affections of the eye.

LECTURE 4.—Gouty, rheumatic, and tubercular affections of the eye

LECTURE 5.—Glaucoma.

LECTURE 6.—Ocular therapeutics.

Insanity : Its Medical and Legal Treatment.

BY GEO. H. SAVAGE, M.D., F.R.C.P.,

Lecturer on Mental Diseases, Guy's Hospital Medical School.

Wednesdays, at 5 P.M., commencing March 7th.

Fee :—One guinea.

OUTLINE OF COURSE.

Medical, social, and legal relationships of Insanity.

Forms of Insanity and their relations to allied normal conditions.

Origin of Insanity, as a disorder, as a disease of the brain, as a symptom of bodily disease.

Development of symptoms, course and termination of the disorder.

Social and legal responsibilities involved in treatment.

Diseases of the Skin.

A course of six demonstrations will be given by P. S. Abraham, M.A., M.D., F.R.C.S. (Surgeon to the Hospital for Diseases of the Skin), on Wednesdays, at 5 P.M., commencing March 7th.

A number of cases will be shown at each demonstration, and especial attention will be given to their diagnosis and treatment.

Comparative Pathology.

BY WOODS HUTCHINSON, A.M., M.D.,

Professor of Comparative Pathology in the University of Buffalo, U.S.A.

Thursdays, at 3 P.M., commencing March 8th.

Fee :—One guinea.

I. Diseases of the Alimentary Canal, their Similarities and Differences in the various Classes of Animals. Diseases of the Stomach in Carnivora. Diseases of the Stomach in Herbivora. Diseases of the Stomach in Mixed Feeders.

II. Diseases of the Small Intestine. Diseases of the various Types of Cæcum.

III. Diseases of the Lungs and Chest Walls in various Classes : Pneumonias, Bronchitis, Influenza, Pleurisies.

IV. Deformities of the Chest in relation to Types of Respiration.

V. Diseases of the Heart and Blood: Valvular Lesions, Myopathies, Affections of the Vessel-Walls, Anæmias, Hæmoglobinuria of Horses.

VI. Diseases of the Kidneys, Skin, and Appendages: Nephritis and its Consequences, Affections of the Urine, Eczema, Acne, Psoriasis, Scabies.

VII. Tumours in Mammals, Birds, and Fishes. Analogous processes in Plants.

VIII. Diseases of Genito-Urinary Organs: Cystitis, Stone, Syphilis, Menstrual Disturbances.

IX. Gout in Animals and Birds.

X. Tubercle in Animals and Birds. Avian, Bovine, and Human Types of the Disease.

XI. Tubercle, Zoological Distribution. Susceptibility and Immunity of various Classes.

XII. Types of Tubercular Disease according to Host. Methods of preventing its spread.

Administration of Anæsthetics.

BY J. F. W. SILK, M.D.,

Anæsthetist, King's College Hospital.

Mondays, at 2 P.M., commencing March 5th.

Fee:—One guinea.

CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology.

BACTERIOLOGICAL LABORATORIES, KING'S COLLEGE, STRAND, W.C.

Director.—Professor CROOKSHANK.

Demonstrator.—Dr. NEWMAN, D.P.H.

Assistant Demonstrator.—Dr. NASH, D.P.H.

(A) POST-GRADUATE CLASS.

Daily, 10 A.M. to 1 P.M., and 2 P.M. to 5 P.M., for 30 days, commencing Monday, March 5th.

Fee:—Five guineas.

The Secretary for the Colonies has intimated to the Council of King's College that, in selecting candidates for the Colonial Medical Services, preference will be given (other things being equal) to qualified medical men who have received such bacteriological or similar special training as King's College provides.

A Certificate is granted for this Course.

This course includes admission to the Laboratory for practical work daily for a month during term, and attendance upon a course of Demonstrations on the following subjects :—

SYLLABUS.

(a) MICROSCOPE—

Lenses—Spherical aberration—Chromatic aberration—Dry, water, and oil immersion objectives—The Stand—Ross model—Jackson model.

Illumination—Daylight and Artificial light—Abbé condenser—Microscopical accessories—Micro-photography.

(b) MICROSCOPICAL METHODS—

Examination of fresh specimens—Cover-glass preparations—Ehrlich's method—Ziehl-Neelsen method—Gram's method, &c.

Preparation of morbid specimens—Hardening—Embedding—Celloidin—Microtomes and section cutting.

(c) CULTIVATION METHODS—

Principles of sterilization—Bacteriological apparatus—Preparation of nutrient gelatine; nutrient agar-agar; glycerine agar-agar; blood serum; potato cultivations—Elsner medium.

Test-tube cultivations—Plate cultivations—Drop cultivations—Examination of air, soil, water, milk, and sewage effluents.

(d) BIOLOGY OF BACTERIA—

Chemical composition—Respiration and nutrition—Form—Classification—Circumstances affecting growth; products of growth—Chromogenic, zymogenic, septic, and pathogenic bacteria—Nitrification.

Ptomaines—Toxines and Antitoxines—Vaccines—Attenuation of virus—Protective inoculation—Immunity—Serum Therapeutics.

Disinfection—Antiseptics.

(e) INFECTIVE DISEASES—

Anthrax—Symptomatic anthrax—Malignant oedema.

Tuberculosis—Leprosy—Actinomycosis—Madura foot.

Glanders—Syphilis—Beri-beri—Yaws—Verruga pernana.

Typhoid fever—Tropical typhoid—Dysentery.

Swine fever—Swine measles.

Cholera—Relapsing fever—Malaria—Dengue—Malta fever—Surra.

Pneumonia—Rabbit septicæmia—Chicken cholera.
 Mouse septicæmia—Suppuration and septic complication—Tropical abscess—
 Strangles.
 Tetanus—Rabies.
 Scarlet fever—Diphtheria—Small-pox.
 Cow-pox—Horse-pox—Sheep-pox.
 Foot and mouth disease—Pleuro-pneumonia—Cattle-plague.
 Influenza—Plague—Yellow fever.
 Oriental sore—Human and Bovine ringworm.

The courses of instruction are similar to those given at the Pasteur Institute (Paris), and the Hygienic Institute (Berlin).

Text-Book of the Laboratory — “Crookshank’s Bacteriology and Infective Diseases.”

(B) CLINICAL CLASS.

Wednesdays, 2 to 3.30 P.M.

Six clinical demonstrations, with practical work, will be given on Wednesdays, commencing March 7th.

Fee :—Two guineas.

- (1) Micrococci—Bacillus of Anthrax.
- (2) Tubercle and Leprosy bacilli.
- (3) Actinomyces fungus.
- (4) Plague and Influenza bacilli.
- (5) Diphtheria and Tetanus bacilli.
- (6) Cholera bacillus—Malarial parasites.

Demonstrations will be given on each of the above subjects, and an opportunity given to every member of the class to examine sputum, &c., and to make a series of permanent preparations of the bacteria referred to above. Each student is provided with a microscope and all materials.

Mental Diseases.

BETHLEM ROYAL HOSPITAL FOR LUNATICS.

Lecturer.—MAURICE CRAIG, M.D., M.R.C.P.

Tuesdays, 2 P.M., commencing March 6th.

Fee :—One guinea.

- March 6.—Mania—Acute; Hysterical; Acute Delirious.
 „ 13.—Melancholia; Hypochondriasis; and Stupor.
 „ 20.—Delusional Insanity. Impulsive Insanities.

March 27.—Alcoholic Insanity. Lunacy Law.

April 3.—General Paralysis.

„ 10.—Puerperal, Lactational, and Climacteric Insanities
Dementia.

Hygiene and Public Health.

BY WYNTER BLYTH, F.I.C., F.C.S.

LECTURE I.—AIR.—Composition of air. Impurities in air. Methods of estimation of carbon dioxide. Methods of estimation of carbon monoxide. Cubic space. General laws of ventilation. Ventilators. Methods of warming and ventilation.

LECTURE II.—CONSTRUCTION OF DWELLING-HOUSES.—Varieties of Dwelling-houses. Site, and means of obtaining sunlight and breeze. General construction. Methods of excluding ground air, vapour, dampness, and rain. Rooms, and internal arrangements of house. Surroundings of house.

LECTURE III.—HOUSE DRAINAGE.—Laying of Drains. Disconnection. Ventilation. Soil Pipes. Anti-Siphonage and Ventilation. Testing Drains and Soil Pipes.

LECTURE IV.—SANITARY APPLIANCES.—Water-Closets. Slop-Sinks. Urinals. Baths. Sinks. Treatment of Waste Pipes. Gullies. Defective Sanitary Arrangements.

LECTURE V.—REFUSE REMOVAL AND DISPOSAL.—Solid, liquid, and excretal refuse. Dry systems. Fixed and movable receptacles. Disposal of various kinds of solid refuse. Deposition. Utilisation. Destruction. Separate and combined systems of sewerage. Disposal of Sewage. Clarification. Precipitation. Filtration. Irrigation.

LECTURE VI.—SOURCES OF WATER.—Town and Country supplies. Pollution. Purification. Detection of Impurities. The Law as to Water Supply.

LECTURE VII.—INFECTIOUS DISEASES.—Incubation Periods. Duration of Infectivity. Compulsory Notification. Isolation. Removal to Hospital. Quarantine. School Closure. Fever and Small-pox Hospitals.

LECTURE VIII.—DISINFECTION AND DISINFECTANTS.—Deodorants. Preservatives. Antiseptics. Germicides. Chemical and Physical Germicides. Disinfection of interiors. Contained Air, Surfaces, and Contents of Infected Rooms. Treatment of various Infected Objects.

This class will be conducted at the Parkes Museum, Margaret Street, W.
Date of first meeting, Wednesday, March 7th, at 4.30 P.M. Fee :—Two guineas.

DIARY FOR MARCH.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m. Committees at 5.15 p.m.

1	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.
2	Friday	....	Cons. (Ophth.).	Mr. Holmes Spicer.
3	Saturday	....	
4	SUNDAY	....	
5	Monday	....	Cons. (Dermat.).	Dr. Galloway.
6	Tuesday	....	Cons. (Med.).	Sir Wm. Broadbent.
7	Wednesday	....	Cons. (Surg.).	Mr. Berry. Tuberculosis Committee, 5.15.
8	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.
9	Friday	....	Cons. (Ear and Throat).	Mr. R. Lake.
10	Saturday	....	
11	SUNDAY	....	
12	Monday	....	Cons. (Dermat.).	Dr. Colcott Fox.
13	Tuesday	....	Cons. (Med.).	Dr. Ord.
14	Wednesday	....	Clin. Lecture.	Dr. R. Saundby.
15	Thursday	....	Cons. (Surg., &c.).	Mr. Hutchinson.
16	Friday	....	Cons. (Throat and Nose).	Dr. Tilley.
17	Saturday	....	
18	SUNDAY	....	
19	Monday	....	Cons. (Dermat.).	Dr. Galloway.
20	Tuesday	....	Cons. (Med.).	Sir Wm. Broadbent.
21	Wednesday	....	Cons. (Med.).	Dr. Hawthorne. Committee on South Africa.
22	Thursday	....	Cons. (Surg., &c.).	Mr. Hutchinson.
23	Friday	....	Cons. (Throat, &c.).	Dr. StClair Thomson.
24	Saturday	....	
25	SUNDAY	....	
26	Monday	....	Cons. (Dermat.).	Dr. Whitfield.
27	Tuesday	....	Cons. (Med.).	Dr. Ord.
28	Wednesday	....	Clin. Lecture.	Mr. Hutchinson. Annual Meeting
29	Thursday	....	Cons. (Surg., &c.).	Mr. Hutchinson.
30	Friday	....	Cons. (Eye).	Mr. Treacher Collins.
31	Saturday	....	

DIARY FOR MARCH.

APPOINTMENTS AT OTHER INSTITUTIONS, SOCIETIES, &c.

1	Thursday	....	Röntgen Society, 8.	Harveian Society, 8.30.
2	Friday	....	
3	Saturday	....	
4	SUNDAY	....	
5	Monday	....	Medical Society, Lettsomian Lecture, 9.	
6	Tuesday	....	Pathological Society, 8.30.	
7	Wednesday	....	Obstetrical Society, 8.	
8	Thursday	....	British Gynecological Society, 8.	Ophthalmological Society, 8.30. Balneological Society, 8.30.
9	Friday	....	Clinical Society, 8.30.	
10	Saturday	....	
11	SUNDAY	....	
12	Monday	....	Medical Society, 8.30.	
13	Tuesday	....	Medico-Chirurgical Society, 8.30.	
14	Wednesday	....	Dermatological Society of London, 5.15.	
15	Thursday	....	Harveian Society, 8.30.	
16	Friday	....	Epidemiological Society, 8.30.	
17	Saturday	....	
18	SUNDAY	....	
19	Monday	....	Medical Society, Lettsomian Lecture, 9.	
20	Tuesday	....	Pathological Society, 8.30.	
21	Wednesday	....	
22	Thursday	....	
23	Friday	Clinical Society, 8.30.	
24	Saturday		
25	SUNDAY		
26	Monday	Medical Society, 8.30.	
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28	Wednesday	Dermatological Society of Great Britain, 5.	
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30	Friday		
31	Saturday		

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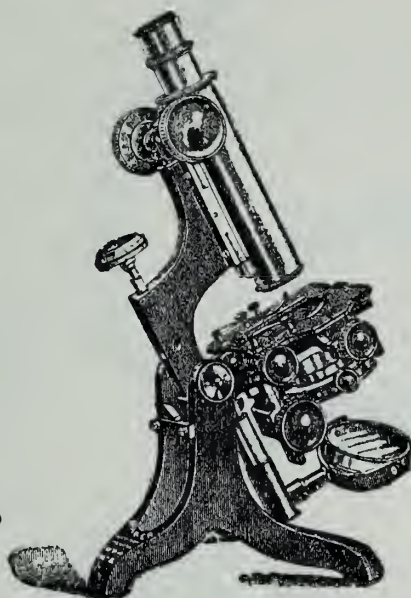
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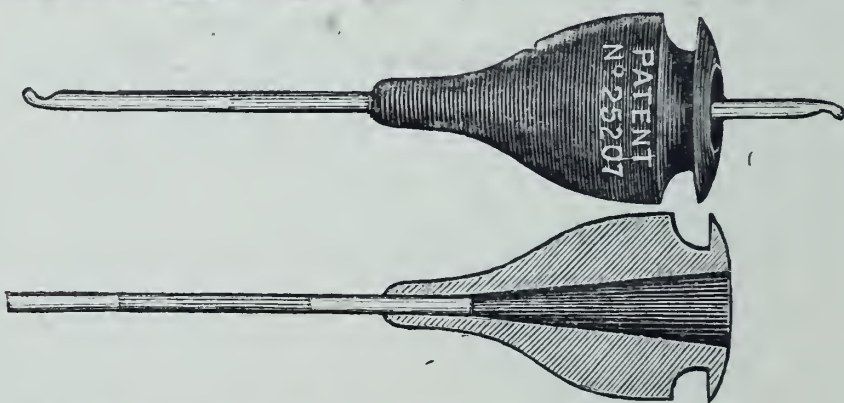


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Clinical Examination of the Nervous System	{	James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.
Practical Ophthalmology : the use of the Ophthalmoscope and Refraction	{	E. Treacher Collins, F.R.C.S. W. Holmes Spicer M.B., F.R.C.S. John Griffith, F.R.C.S.
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Practical Rhinology and Laryngology	{	StClair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P.
The Application of the Röntgen Rays		F. Harrison Low, M.B.
Clinical Microscopy		A. E. Hayward Pinch, F.R.C.S.

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LENT TERM, 1900.

Commenced Monday, March 5th ; ends Thursday, April 12th.

CLINICAL CONSULTATIONS AT 4 P.M.

Mondays (Skin) ; Tuesdays (Medical) ; Wednesdays (Various) ;
Thursdays (Surgical) ; Fridays (Eye, Ear, Throat, and Nose).

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Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commenced Wednesday, March 7th. Fee, £2 2s. Dr. StClair Thomson.

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These will take place in the afternoon, between the hours of 4 and 6. Particulars will be announced at the Polyclinic, in the Journal, and in the weekly Medical Press. In connection with these Consultations, Clinical Assistants will be appointed. For the present, Consultations will be held every Monday, Tuesday, Wednesday, Thursday, and Friday.

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Entries for the following Practical Classes may now be made. *Each course will extend over six weeks*, and will be conducted so as to afford practical instruction to each member of the class. Patients illustrating the various diseased conditions will be submitted for examination. The number of students permitted in each class will be limited, but, if required, supplementary classes will be provided :—

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Tuesdays and Thursdays, 6 to 7 P.M., commenced March 6th.

*Fee :—*Two guineas.

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2. The principles and methods of case-taking.
3. The application of inspection, palpation, mensuration, percussion, and auscultation in the clinical study of the thoracic and abdominal viscera.

* All communications regarding the classes should be addressed to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

4. The use of medical instruments and apparatus, with demonstrations of methods and results. In this section will be studied the Cardiograph, Sphygmograph, Pneumograph, and records obtained by their aid; the Clinical Thermometer and Temperature Charts; the Hypodermic Syringe and its use; the Stomach Pump and Stomach Syphon; Southey's Tubes and various Aspirators; Inhalers and Intra-Laryngeal Medication; Enemata, their preparation and use; Venesection, Transfusion, &c., &c.

5. BONES.—Mechanism; structure as bearing on fractures.

6. JOINTS.—Anatomy; dislocations and principles of reduction.

7. MUSCLES.—Grouping of muscles according to action and nervous supply; tendons, their sheaths and division points; club foot.

8. ARTERIES.—Anatomy of main arteries; points at which pressure is most readily applied; sites for ligature; collateral circulation; tourniquets.

9. VEINS.—Anatomy; venesection; varicose veins.

10. LYMPHATIC SYSTEM.—Grouping of glands; distribution of lymphatics.

11. NERVOUS SYSTEM.—Brain, and the localisation of cranial lesions; the convolutions, centres, origins of cranial nerves, vascular supply, relations to surface of skull; trephining. Cranial nerves, anatomy, diagnosis of lesions affecting. Spinal nerves, their area of supply; localisation of spinal lesions; laminectomy; operations for spina bifida.

12. REGIONS.—Cranium; orbital, nasal, oral, and aural regions and cavities. Limbs, the surgical anatomy of. Fractures, their anatomy, and principles of treatment. The surgical anatomy of hernia and the genito-urinary organs.

Bandaging. Application of splints. Surgical instruments.

THE METHODS OF INVESTIGATING CASES OF DISEASE OF THE NERVOUS SYSTEM.

Fridays, 2 to 3.30 P.M., commenced March 9th.

Fee:—Two guineas.

The anatomy and physiology of the nervous system.

Brain and spinal cord topography.

Functions of the brain and spinal cord.

Family history in nervous disease.

Personal history and habits in nervous disease.

Condition of the patient at the time of examination.

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Sensory Symptoms.—Spontaneous sensations; impaired sensibility, common, for pain, for heat and cold; perverted sensibility, allocheiria, &c.

Special Senses.—Smell; taste; vision; ophthalmoscopic appearances; hearing.

Trophic symptoms.

Cases illustrating different types of nervous disease.

THE USE OF THE RÖNTGEN RAYS IN MEDICINE AND SURGERY.

Thursdays, at 3 P.M., commenced March 8th.

This subject will be taught in the laboratory, which has recently been equipped with the most modern apparatus. Instruction will be given in short courses of practical work under the supervision of Dr. Harrison Low, and each member of the class will have the opportunity of practising the necessary methods and processes. It is proposed that the laboratory shall be open for teaching on Thursdays at 3 P.M., but in respect to days and hours, an endeavour will be made to meet the convenience of practitioners wishing to study this subject. Fee for four practical lessons:—Two guineas.

PRACTICAL OPHTHALMOLOGY: THE USE OF THE OPHTHALMOSCOPE AND REFRACTION.

Fridays, 5 to 7 P.M., commenced March 9th.

Fee:—Two guineas.

- I. Optical principles and subjective testing.
- II. The ophthalmoscope, and how to use it.

- III. Retinoscopy.
- IV. Abnormalities of refraction and the prescribing of glasses.
- V. Ocular movements: their anomalies and derangements.
- VI. The field of vision.

PRACTICAL RHINOLOGY AND LARYNGOLOGY.

Wednesdays, 5 to 7 P.M., commenced March 7th.

Fec:—Two guineas.

Members of the class are requested to provide their own laryngoscopes and the ordinary instruments required for clinical examination. (A list of these will be provided by the teacher.) The class is held in the dark room, and for each member there is a separate table and laryngoscope lamp.

The practical examination of the upper air passages will be demonstrated on patients, and the course will be illustrated by instruments, models, drawings, diagrams, and specimens.

March 7.—Methods of illumination; position; necessary instruments; the external nose.

„ 14.—The examination of the nasal fossæ; specula; probes; cocaine; the medication of the nasal cavity, composition of nasal lotions, &c.; affections of the septum.

„ 21.—The accessory sinuses of the nose, their situations, openings, relations, and the methods of their exploration; transillumination; the physiology of smell and of nasal respiration.

„ 28.—The naso-pharynx and pharynx; the tonsils.

April 4.—The larynx.

„ 11.—The trachea and œsophagus; tracheotomy; intubation; dysphagia.

PRACTICAL OTOLOGY.

Mondays, 5 to 7 P.M., commenced March 5th.

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- I. Inspection of auricle, meatus and membrane, specula, &c.; air and bone conduction; tests for hearing; rules for using the tuning-fork, Rinne's test, &c. (Cases.)

- II. Diagnosis of obstructive and nerve deafness in general ; cerumen ; indrawn membrane, dry perforations, cicatrices, &c. ; Siegel's speculum, "artificial drum," &c. Syringing. (Cases.)
- III. Varieties of obstructive deafness ; examination of the Eustachian tubes, rhinoscopy, inflation, auscultation, Politzer's bag, Eustachian catheter, &c. (Cases.)
- IV. Discharges from the ear, cleansing, instillation of drops, cauterisation, &c. ; mastoid disease, &c., polypi, granulations, "attic disease." (Cases.)
- V. Varieties of nerve-deafness, labyrinthine, central, functional, &c. ; use of Galton's whistle, &c. ; investigation of auditory and neighbouring nerves, &c. (Cases.)
- VI. Varieties of tinnitus aurium ; compression of vertebral arteries ; application of galvanism. (Miscellaneous cases.)

On each occasion the members of the class will receive a typed *résumé* of the matter dealt with. The most of the time will be occupied in the actual examination of cases.

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Fee ;—Two guineas.

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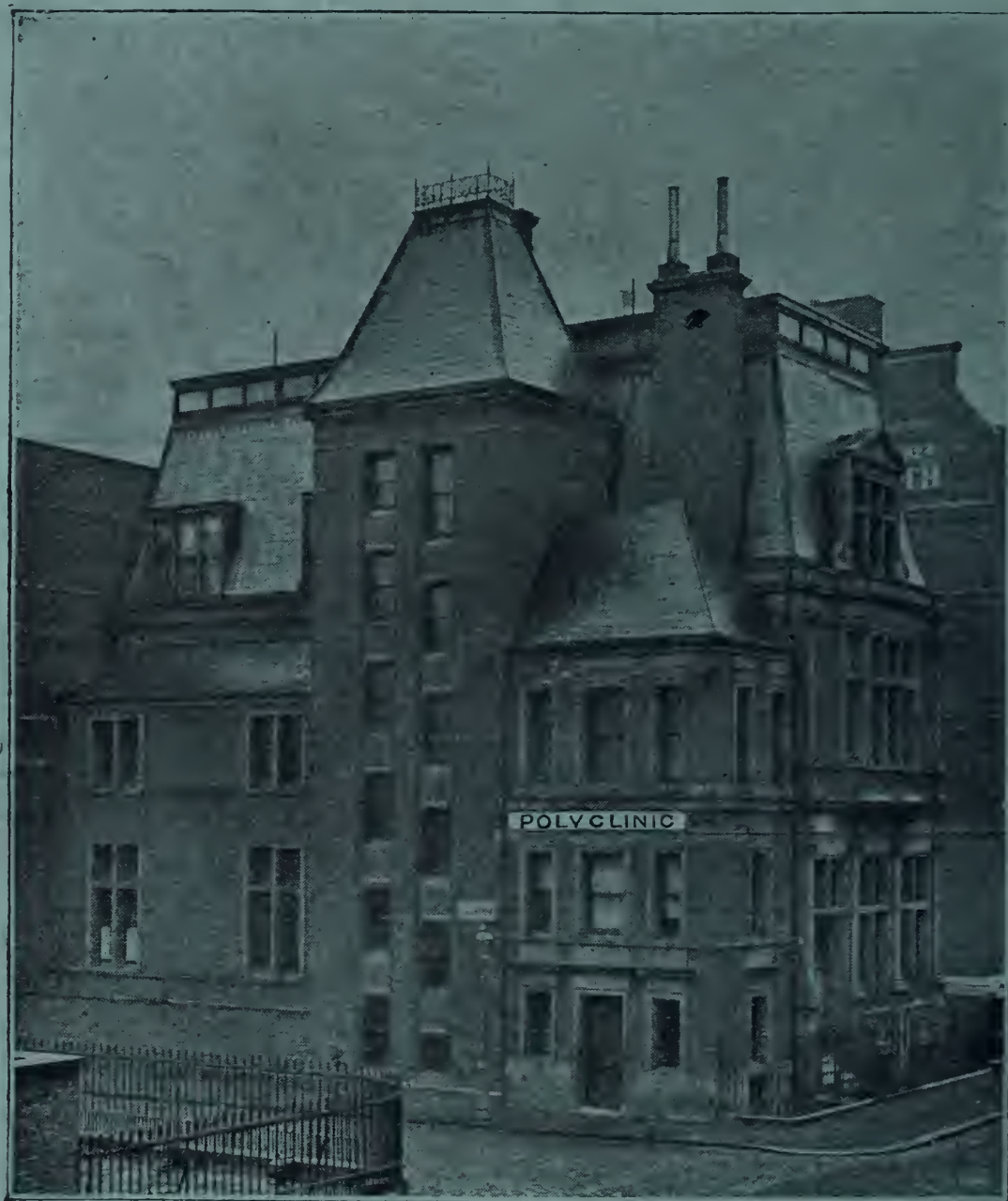
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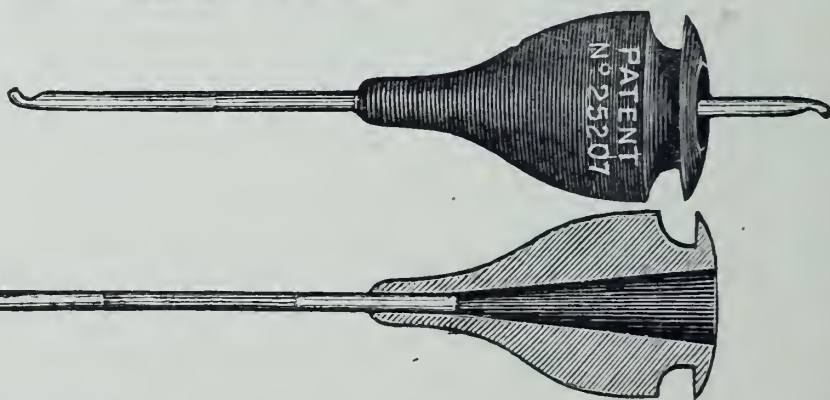


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Practical Application of Röntgen Rays. Thursdays, 3 P.M. Commences Thursday, May 17th. Fee, £2 2s. Dr. Harrison Low.

Practical Ophthalmology : the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M. Commences Friday, May 18th. Fee, £2 2s. Mr. John Griffith.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commences Wednesday, May 16th. Fee, £2 2s. Dr. W. Jobson Horne.

Practical Otology. Mondays, 5 to 7 P.M. Commences Monday, May 14th. Fee, £2 2s. Mr. R. Lake.

Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30 P.M. Commences Monday, May 14th. Fee, £2 2s. Mr. Hayward Pinch.

Composition fee for any three of above courses, £5 5s.

LECTURES.

(Conditional upon a minimum number of entries being received.)

Diseases of the Eye. Mr. Marcus Gunn.

Diseases of the Skin. Dr. Phineas Abraham.

Comparative Pathology. Dr. Woods Hutchinson.

Administration of Anæsthetics. Dr. Silk.

Diseases of Children. Dr. G. F. Still.

Fee for any one course of Six Lectures, £1 1s.

LABORATORY AND CLINICAL CLASSES.

Practical Bacteriology. Daily, 10 A.M. to 1 P.M., and 2 to 5 P.M. Fee, £5 5s. Professor Crookshank.

Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee, £2 2s. Professor Crookshank.

Hygiene and Public Health. Fee, £2 2s. Mr. Wynter Blyth.

Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.

Morbid Conditions of the Urine and their Clinical Significance. Fee, £2 2s.

SYLLABUS OF TEACHING.*

Clinical Lectures will be given on alternate Wednesdays at 5 p.m., commencing May 9th.

CLINICAL CONSULTATIONS.

These will take place in the afternoon, between the hours of 4 and 6. Particulars will be announced at the Polyclinic, in the Journal, and in the weekly Medical Press. In connection with these Consultations, Clinical Assistants will be appointed. For the present, Consultations will be held every Monday, Tuesday, Wednesday, Thursday, and Friday.

PRACTICAL CLASSES.

Entries for the following Practical Classes may now be made. *Each course will extend over six weeks*, and will be conducted so as to afford practical instruction to each member of the class. Patients illustrating the various diseased conditions will be submitted for examination. The number of students permitted in each class will be limited, but, if required, supplementary classes will be provided :—

MEDICAL AND SURGICAL ANATOMY AND PHYSICAL DIAGNOSIS.

Tuesdays and Thursdays, 6 to 7 P.M., commences May 15th.

Fee :—Two guineas.

This course will be illustrated on the living subject, and by specimens, diagrams, and models. It will include—

1. Practical instruction in the normal positions of the several organs and their various parts, and the relationship of surface anatomy to the subjacent viscera.
2. The principles and methods of case-taking.
3. The application of inspection, palpation, mensuration, percussion, and auscultation in the clinical study of the thoracic and abdominal viscera.

* All communications regarding the classes should be addressed to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

4. The use of medical instruments and apparatus, with demonstrations of methods and results. In this section will be studied the Cardiograph, Sphygmograph, Pneumograph, and records obtained by their aid; the Clinical Thermometer and Temperature Charts; the Hypodermic Syringe and its use; the Stomach Pump and Stomach Syphon; Southey's Tubes and various Aspirators; Inhalers and Intra-Laryngeal Medication; Enemata, their preparation and use; Venesection, Transfusion, &c., &c.

5. BONES.—Mechanism; structure as bearing on fractures.

6. JOINTS.—Anatomy; dislocations and principles of reduction.

7. MUSCLES.—Grouping of muscles according to action and nervous supply; tendons, their sheaths and division points; club foot.

8. ARTERIES.—Anatomy of main arteries; points at which pressure is most readily applied; sites for ligature; collateral circulation; tourniquets.

9. VEINS.—Anatomy; venesection; varicose veins.

10. LYMPHATIC SYSTEM.—Grouping of glands; distribution of lymphatics.

11. NERVOUS SYSTEM.—Brain, and the localisation of cranial lesions; the convolutions, centres, origins of cranial nerves, vascular supply, relations to surface of skull; trephining. Cranial nerves, anatomy, diagnosis of lesions affecting. Spinal nerves, their area of supply; localisation of spinal lesions; laminectomy; operations for spina bifida.

12. REGIONS.—Cranium; orbital, nasal, oral, and aural regions and cavities. Limbs, the surgical anatomy of. Fractures, their anatomy, and principles of treatment. The surgical anatomy of hernia and the genito-urinary organs.

Bandaging. Application of splints. Surgical instruments.

THE METHODS OF INVESTIGATING CASES OF DISEASE OF THE NERVOUS SYSTEM.

Fridays, 2 to 3.30 P.M., commences May 18th.

Fee:—Two guineas.

The anatomy and physiology of the nervous system.

Brain and spinal cord topography.

Functions of the brain and spinal cord.

Family history in nervous disease.

Personal history and habits in nervous disease.

Condition of the patient at the time of examination.

General Appearances.—Unsteadiness, tremor, deformities, pallor, nervousness, &c.

Gait—Spastic, ataxic, hemiplegic, functional disturbances.

Spontaneous movements.—Choreiform; athetoid; tremor.

Speech defects—Articulatory; aphasic.

Motor Symptoms.—Paraplegia; monoplegia; hemiplegia; cranial nerve paralyses; isolated paralysis of spinal segments; isolated paralysis of spinal nerves; general neuritis; electrical testing.

Sensory Symptoms.—Spontaneous sensations; impaired sensibility, common, for pain, for heat and cold; perverted sensibility, allocheiria, &c.

Special Senses.—Smell; taste; vision; ophthalmoscopic appearances; hearing.

Trophic symptoms.

Cases illustrating different types of nervous disease.

THE USE OF THE RÖNTGEN RAYS IN MEDICINE AND SURGERY.

Thursdays, at 3 P.M., commences May 17th.

This subject will be taught in the laboratory, which has recently been equipped with the most modern apparatus. Instruction will be given in short courses of practical work under the supervision of Dr. Harrison Low, and each member of the class will have the opportunity of practising the necessary methods and processes. It is proposed that the laboratory shall be open for teaching on Thursdays at 3 P.M., but in respect to days and hours, an endeavour will be made to meet the convenience of practitioners wishing to study this subject. Fee for four practical lessons:—Two guineas.

PRACTICAL OPHTHALMOLOGY: THE USE OF THE OPHTHALMOSCOPE AND REFRACTION.

Fridays, 5 to 7 P.M., commences May 18th.

Fee:—Two guineas.

- I. Optical principles and subjective testing.
- II. The ophthalmoscope, and how to use it.

- III. Retinoscopy.
- IV. Abnormalities of refraction and the prescribing of glasses.
- V. Ocular movements: their anomalies and derangements.
- VI. The field of vision.

PRACTICAL LARYNGOLOGY AND RHINOLOGY.

Wednesdays, 5 to 7 P.M., commences May 16th.

Fee :—Two guineas.

The class is held in the dark room, and for each member there is a separate table and electric laryngoscope lamp. The course will comprise full instruction in the ordinary and special methods of examining the throat and nose and the associated sinuses, with a view to—

1. The diagnosis and treatment of diseases affecting these regions; and
2. The elucidation of the relations which exist between diseases of these regions and other diseases met with in general practice.

Cases will be shown to exemplify the diseases discussed, and for instruction in the methods of examination.

On each occasion the class meets, and preceding the practical work, the work for the day will be briefly explained, the instruments required for the examination and treatment of the cases will be shown and demonstrated, and lantern demonstrations of photographs taken from living and dead subjects, to illustrate normal and abnormal conditions, will be given.

The greatest part of the time will be devoted to the clinical examination of patients.

PRACTICAL OTOLOGY.

Mondays, 5 to 7 P.M., commences May 14th.

Fee :—Two guineas.

Each Clinic will be divided into two parts: one part will consist of a demonstration of cases, the other of a lecture.

Cases (1st hour).

- No. 1.—Normal membrane. Various grades and degrees of retraction and changes in the membrana tympani in chronic otitis media non-suppurativa.
- No. 2.—Atrophy and hypertrophy of the membrana tympani.
- No. 3.—Chronic otitis media suppurativa. Polypi, cholesteatomata, &c.
- No. 4.—Nerve deafness.
- No. 5.—Ditto, secondary to otitis media suppurativa sicca.
- No. 6.—Deformities, malformations, deaf mutism, &c.

Lectures (2nd hour).

- No. 1.—Instruments used in diagnosis and treatment, and their usage. The examination of cases with the necessary tuning-fork tests, &c.
- No. 2.—Diseases of the external meatus and auricle.
- No. 3.—Diseases characterised by discharge from the ear.
- No. 4.—Aural polypi and conditions secondary to post-nasal adenoids.
- No. 5.—Nerve deafness.
- No. 6.—Operations for operating on the mastoid, or “Chronic dry catarrh of the middle ear.”

CLINICAL MICROSCOPY.

Mondays and Wednesdays, 2 to 3.30 P.M., commences May 14th.

Fee :—Two guineas.

Syllabus.

The Microscope. Lenses and Objectives. Spherical and chromatic aberration. Abbé condenser. Conditions of visibility of microscopic objects seen by transmitted light. Refraction images, colour images.

The objects and chemical principles of staining.

The preparation of blood films. Diapedesis and phagocytosis.

Sterilization. Culture media and their preparation. Drop, Test-tube, Stab, Stroke, and Plate cultivations.

Bacteria, their structure and chemical composition. Morphological classification, method of growth and reproduction, products of growth. Classification of bacterial diseases.

Immunity, autogenous and heterogenous. Mithridatism. Toxines and antitoxines. Variolization and vaccination, preventive serums.

Septicæmic Processes—Anthrax, Syphilis, Typhoid.

Local Inflammatory Processes—Staphylococcus and Streptococcus Pyogenes aureus, Frankel's pneumococcus, gonococcus, glanders, tuberculosis.

Intoxication Processes. Tetanus. Diphtheria.

Rabies. Pasteurism.

The preparation of microscopic sections.

Fresh specimens. Hardened specimens. Methods of hardening, embedding, cutting and mounting sections. Microtomes.

Inflammations. Infiltrations, Degenerations, Amyloid Disease.

Tumours—

(a) Connective tissue. Innocent and malignant.

(b) Epithelial tissue. Innocent and malignant.

(c) Cysts.

MORBID CONDITIONS OF THE URINE AND THEIR CLINICAL SIGNIFICANCE.

Fee :—Two guineas.

Particulars on application.

COURSES OF LECTURES.

General Ophthalmology.

BY R. MARCUS GUNN, F.R.C.S.,

Surgeon to the Royal Ophthalmic Hospital, Moorfields, &c.

Fridays, at 3 P.M.

Fee :—One guinea.

LECTURE 1.—On the external examination of the eye.

LECTURE 2.—Visual tests.

LECTURE 3.—Syphilitic affections of the eye.

LECTURE 4.—Gouty, rheumatic, and tubercular affections of the eye.

LECTURE 5.—Glaucoma.

LECTURE 6.—Ocular therapeutics.

Diseases of Children.

BY G. F. STILL, M.A., M.D., M.R.C.P.,

Assistant Physician, Diseases of Children, King's College Hospital; Assistant Physician, Hospital for Sick Children, Great Ormond Street.

Tuesdays, at 5 P.M.

Fee for Course of Six Lectures :—One guinea.

Diseases of the Skin.

A course of six demonstrations will be given by P. S. Abraham, M.A., M.D., F.R.C.S. (Surgeon to the Hospital for Diseases of the Skin), on Wednesdays, at 5 P.M.

A number of cases will be shown at each demonstration, and especial attention will be given to their diagnosis and treatment.

Comparative Pathology.

BY WOODS HUTCHINSON, A.M., M.D.,

Professor of Comparative Pathology in the University of Buffalo, U.S.A.

Thursdays, at 3 P.M.

Fee :—One guinea.

I. Diseases of the Alimentary Canal, their Similarities and Differences in the various Classes of Animals. Diseases of the Stomach in Carnivora. Diseases of the Stomach in Herbivora. Diseases of the Stomach in Mixed Feeders.

II. Diseases of the Small Intestine. Diseases of the various Types of Cæcum.

III. Diseases of the Lungs and Chest Walls in various Classes : Pneumonias, Bronchitis, Influenza, Pleurisies.

IV. Deformities of the Chest in relation to Types of Respiration.

V. Diseases of the Heart and Blood : Valvular Lesions, Myopathies, Affections of the Vessel-Walls, Anæmias, Hæmoglobinuria of Horses.

VI. Diseases of the Kidneys, Skin, and Appendages: Nephritis and its Consequences, Affections of the Urine, Eczema, Acne, Psoriasis, Scabies.

VII. Tumours in Mammals, Birds, and Fishes. Analogous processes in Plants.

VIII. Diseases of Genito-Urinary Organs: Cystitis, Stone, Syphilis, Menstrual Disturbances.

IX. Gout in Animals and Birds.

X. Tubercle in Animals and Birds. Avian, Bovine, and Human Types of the Disease.

XI. Tubercle, Zoological Distribution. Susceptibility and Immunity of various Classes.

XII. Types of Tubercular Disease according to Host. Methods of preventing its spread.

Administration of Anæsthetics.

BY J. F. W. SILK, M.D.,

Anæsthetist, King's College Hospital.

Mondays, at 2 P.M.

Fee:—One guinea.

CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology.

BACTERIOLOGICAL LABORATORIES, KING'S COLLEGE, STRAND, W.C.

Director.—Professor CROOKSHANK.

Demonstrator.—Dr. NEWMAN, D.P.H.

Assistant Demonstrator.—Dr. NASH, D.P.H.

(A) POST-GRADUATE CLASS.

Daily, 10 A.M. to 1 P.M., and 2 P.M. to 5 P.M., for 30 days.

Fee:—Five guineas.

The Secretary for the Colonies has intimated to the Council of King's College that, in selecting candidates for the Colonial Medical Services, preference will be given (other things being equal) to qualified medical men who have received such bacteriological or similar special training as King's College provides.

A Certificate is granted for this Course.

This course includes admission to the Laboratory for practical work daily for a month during term, and attendance upon a course of Demonstrations on the following subjects :—

SYLLABUS.

(a) MICROSCOPE—

Lenses—Spherical aberration—Chromatic aberration—Dry, water, and oil immersion objectives—The Stand—Ross model—Jackson model.
Illumination—Daylight and Artificial light—Abbé condenser—Microscopical accessories—Micro-photography.

(b) MICROSCOPICAL METHODS—

Examination of fresh specimens—Cover-glass preparations—Ehrlich's method—Ziehl-Neelsen method—Gram's method, &c.
Preparation of morbid specimens—Hardening—Embedding—Celloidin—Microtomes and section cutting.

(c) CULTIVATION METHODS—

Principles of sterilization—Bacteriological apparatus—Preparation of nutrient gelatine; nutrient agar-agar; glycerine agar-agar; blood serum; potato cultivations—Elsner medium.
Test-tube cultivations—Plate cultivations—Drop cultivations—Examination of air, soil, water, milk, and sewage effluents.

(d) BIOLOGY OF BACTERIA—

Chemical composition—Respiration and nutrition—Form—Classification—Circumstances affecting growth; products of growth—Chromogenic, zymogenic, septic, and pathogenic bacteria—Nitrification.
Ptomaines—Toxines and Antitoxines—Vaccines—Attenuation of virus—Protective inoculation—Immunity—Serum Therapeutics.
Disinfection—Antiseptics.

(e) INFECTIVE DISEASES—

Anthrax—Symptomatic anthrax—Malignant œdema.
Tuberculosis—Leprosy—Actinomycosis—Madura foot.
Glanders—Syphilis—Beri-beri—Yaws—Verruga pernana.
Typhoid fever—Tropical typhoid—Dysentery.
Swine fever—Swine measles.
Cholera—Relapsing fever—Malaria—Dengue—Malta fever—Surra.

Pneumonia—Rabbit septicæmia—Chicken cholera.

Mouse septicæmia—Suppuration and septic complication —Tropical abscess—Strangles.

Tetanus—Rabies.

Scarlet fever—Diphtheria—Small-pox.

Cow-pox—Horse-pox—Sheep-pox.

Foot and mouth disease—Pleuro-pneumonia—Cattle-plague.

Influenza—Plague—Yellow fever.

Oriental sore—Human and Bovine ringworm.

The courses of instruction are similar to those given at the Pasteur Institute (Paris), and the Hygienic Institute (Berlin).

Text-Book of the Laboratory—*Crookshank's Bacteriology and Infective Diseases*.

(B) CLINICAL CLASS.

Wednesdays, 2 to 3.30 P.M.

Six clinical demonstrations, with practical work, will be given on Wednesdays.

Fee :—Two guineas.

(1) Micrococci—Bacillus of Anthrax.

(2) Tubercle and Leprosy bacilli.

(3) Actinomyces fungus.

(4) Plague and Influenza bacilli.

(5) Diphtheria and Tetanus bacilli.

(6) Cholera bacillus—Malarial parasites.

Demonstrations will be given on each of the above subjects and an opportunity given to every member of the class to examine sputum, &c., and to make a series of permanent preparations of the bacteria referred to above. Each student is provided with a microscope and all materials.

Mental Diseases.

BETHLEM ROYAL HOSPITAL FOR LUNATICS.

Lecturer.—MAURICE CRAIG, M.D., M.R.C.P.

Tuesdays, 2 P.M.

Fee :—One guinea.

LECTURE 1.—Mania—Acute; Hysterical; Acute Delirious.

LECTURE 2.—Melancholia; Hypochondriasis; and Stupor.

LECTURE 3.—Delusional Insanity. Impulsive Insanities.

LECTURE 4.—Alcoholic Insanity. Lunacy Law.

LECTURE 5.—General Paralysis.

LECTURE 6.—Puerperal, Lactational, and Climacteric Insanities.
Dementia.

Hygiene and Public Health.

BY WYNTER BLYTH, F.I.C., F.C.S.

LECTURE I.—AIR.—Composition of air. Impurities in air. Methods of estimation of carbon dioxide. Methods of estimation of carbon monoxide. Cubic space. General laws of ventilation. Ventilators. Methods of warming and ventilation.

LECTURE II.—CONSTRUCTION OF DWELLING-HOUSES.—Varieties of Dwelling-houses. Site, and means of obtaining sunlight and breeze. General construction. Methods of excluding ground air, vapour, dampness, and rain. Rooms, and internal arrangements of house. Surroundings of house.

LECTURE III.—HOUSE DRAINAGE.—Laying of Drains. Disconnection. Ventilation. Soil Pipes. Anti-Siphonage and Ventilation. Testing Drains and Soil Pipes.

LECTURE IV.—SANITARY APPLIANCES.—Water-Closets. Slop-Sinks. Urinals. Baths. Sinks. Treatment of Waste Pipes. Gullies. Defective Sanitary Arrangements.

LECTURE V.—REFUSE REMOVAL AND DISPOSAL.—Solid, liquid, and excretal refuse. Dry systems. Fixed and movable receptacles. Disposal of various kinds of solid refuse. Deposition. Utilisation. Destruction. Separate and combined systems of sewerage. Disposal of Sewage. Clarification. Precipitation. Filtration. Irrigation.

LECTURE VI.—SOURCES OF WATER.—Town and Country supplies. Pollution. Purification. Detection of Impurities. The Law as to Water Supply.

LECTURE VII.—INFECTIOUS DISEASES.—Incubation Periods. Duration of Infectivity. Compulsory Notification. Isolation. Removal to Hospital. Quarantine. School Closure. Fever and Small-pox Hospitals.

LECTURE VIII.—DISINFECTION AND DISINFECTANTS.—Deodorants. Preservatives. Antiseptics. Germicides. Chemical and Physical Germicides. Disinfection of interiors. Contained Air, Surfaces, and Contents of Infected Rooms. Treatment of various Infected Objects.

This class will be conducted at the Parkes Museum, Margaret Street, W.
Fee :—Two guineas.

DIARY FOR MAY.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m. Committees at 5.15 p.m.

1	Tuesday	....	Cons. (Med.).	Dr. J. F. Payne.
2	Wednesday	....	Cons. (Surg.).	Mr. James Cantlie.
3	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.
4	Friday	....	Cons. (Eye).	Mr. Treacher Collins.
5	Saturday	....	
6	SUNDAY	....	
7	Monday	....	Cons. (Skin).	Dr. J. J. Pringle.
8	Tuesday	....	Cons. (Med.).	Dr. R. L. Bowles.
9	Wednesday	....	Clin. Lecture.	Col. Kenneth McLeod.
10	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.
11	Friday	....	Cons. (Nose and Throat).	Dr. StClair Thomson.
12	Saturday	....	
13	SUNDAY	....	
14	Monday	....	Cons. (Skin).	Dr. Radcliffe Crocker.
15	Tuesday	....	Cons. (Med.).	Dr. Seymour Taylor.
16	Wednesday	....	Cons. (Surg.).	Mr. Reginald Harrison.
17	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.
18	Friday	....	Cons. (Ear).	Dr. Dundas Grant.
19	Saturday	....	
20	SUNDAY	....	
21	Monday	....	Cons. (Skin).	Dr. T. Colcott Fox.
22	Tuesday	....	Cons. (Med.).	Sir William Broadbent.
23	Wednesday	....	Clin. Lecture.	Sir W. T. Gairdner.
24	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.
25	Friday	....	Cons. (Eye).	Mr. Holmes Spicer.
26	Saturday	....	
27	SUNDAY	....	
28	Monday	....	Cons. (Skin).	Mr. Malcolm Morris.
29	Tuesday	....	Cons. (Med.).	Dr. C. Theodore Williams.
30	Wednesday	....	Cons. (Med.).	Sir William Broadbent.
31	Thursday	....	Cons. (Surg.).	Mr. Hutchinson.

DIARY FOR MAY.

APPOINTMENTS AT OTHER INSTITUTIONS, SOCIETIES, &c.

1	Tuesday	....	Pathological Society (King's College), 8.30.
2	Wednesday	....	Obstetrical Society, 8.
3	Thursday	....	Harveian Society, 8.30. Ophthalmological Society, 8.30.
4	Friday	...	
5	Saturday	....
6	SUNDAY	....
7	Monday	....
8	Tuesday	....	Royal Medical and Chirurgical Society, 8.30.
9	Wednesday	....	Dermatological Society of London, 5.15.
10	Thursday	....	British Gynæcological Society, 8.
11	Friday	....	Clinical Society, 8.30.
12	Saturday	....
13	SUNDAY	....
14	Monday	....	Medical Society, 8.
15	Tuesday	....	Pathological Society, 8.30.
16	Wednesday	....
17	Thursday	....	Harveian Society, 8.30.
18	Friday	....	Epidemiological Society, 8.30.
19	Saturday	....
20	SUNDAY	....
21	Monday	....	Medical Society, 8.
22	Tuesday	....	Royal Medical and Chirurgical Society, 8.30.
23	Wednesday	....
24	Thursday	....	Balneological Society, 8.30. Dermatological Society of Great Britain, 5.
25	Friday	....	Clinical Society, 8.30.
26	Saturday	....
27	SUNDAY	....
28	Monday	
29	Tuesday	
30	Wednesday	
31	Thursday	

APPLICATION FOR MEMBERSHIP.



Date

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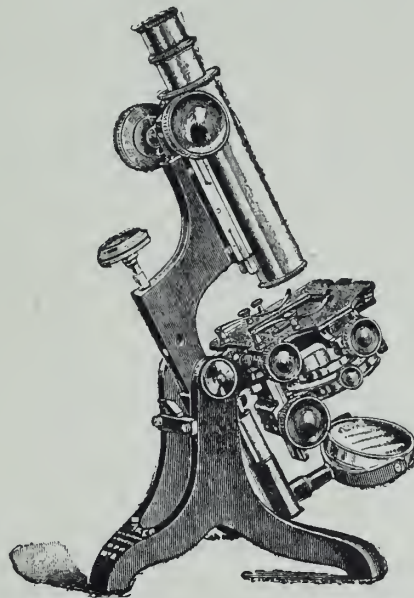
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The year 1898 offers a peculiarly suitable opportunity for New Members to join the Society. With the exception of the LEXICON and ATLAS no serial works are in hand. New Members not wishing to take these works may exchange the Parts for other Volumes of the Society's Publications, and Members wishing to complete them may obtain the back Parts on advantageous terms.

The Series for 1898:—

The **TWENTY-FOURTH PART** of the
LEXICON OF MEDICAL TERMS (Sc—Ta).

The **TWELFTH FASCICULUS** of the
ATLAS OF PATHOLOGY (Lymphadenoma),
HELPERICH'S
ATLAS OF FRACTURES & DISLOCATIONS,

Translated, with many Additional Notes, by JONATHAN HUTCHINSON, Junr., F.R.C.S.

** * Subscriptions for the current year became due in January, and if not already paid should be at once forwarded to the Society's agent. The issue of books for the year commenced in June.*

Those wishing to join the Society should communicate direct with the Hon. Secretary, Mr. JONATHAN HUTCHINSON, 15, Cavendish Square, London, W., or the Society's Agent, from whom copies of the Annual Report containing full particulars may be obtained.

Mr. LEWIS, Agent, 136, Gower Street, London, W.C.

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3	SUNDAY	...	
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5	Tuesday	...	Consultation (Medical). Dr. Ewart.
6	Wednesday	...	Clinical Lecture. Mr. William Rose.
7	Thursday	...	Consultation (Surgical). Mr. Hutchinson.
8	Friday	...	Consultation (Ear). Mr. R. Lake.
9	Saturday	...	
10	SUNDAY	...	
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12	Tuesday	...	Consultation (Medical). Dr. Goodhart.
13	Wednesday	...	Consultation (Surgical). Mr. Berry.
14	Thursday	...	Consultation (Surgical). Mr. Hutchinson.
15	Friday	...	Consultation (Eye). Mr. Holmes Spicer.
16	Saturday	...	
17	SUNDAY	...	
18	Monday	...	Consultation (Skin). Dr. Colcott Fox.
19	Tuesday	...	Consultation (Medical). Dr. Harry Campbell.
20	Wednesday	...	Clinical Lecture. Dr. David Ferrier.
21	Thursday	...	Consultation (Surgical). Mr. Hutchinson.
22	Friday	...	Consultation (Nose and Throat). Dr. StClair Thomson.
23	Saturday	...	
24	SUNDAY	...	
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1	Friday	...	
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3	SUNDAY	...	
4	Monday	...	
5	Tuesday	...	
6	Wednesday	...	Obstetrical Society, 8.
7	Thursday	...	
8	Friday	...	
9	Saturday	...	
10	SUNDAY	...	
11	Monday	...	
12	Tuesday	...	Royal Medical and Chirurgical Society, 8.30.
13	Wednesday	...	
14	Thursday	...	British Gynæcological Society, 8. Ophthalmological Society, 8.30.
15	Friday	...	Opthalmological Society: Bowman Lecture, 8.30.
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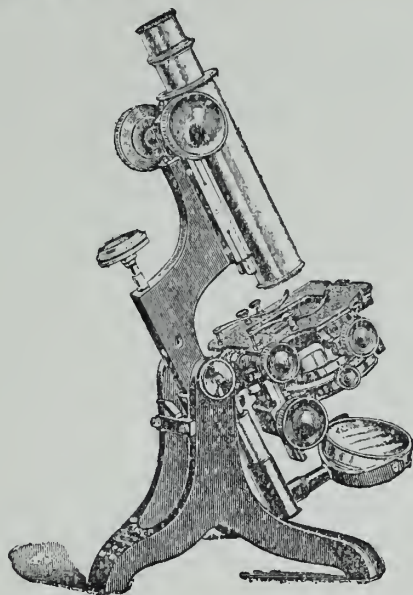
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